MENTAL HYGIENE

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A PSYCHOLOGIST LOOKS AT MENTAL HEALTH IN TO-DAY'S WORLD *

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THE first thing we notice, when we look at mental health in to-day's world, is a point obvious to us all—the great need of modern people for help on mental and emotional problems. Just last week Miss Eleanor Barnes, of the Counseling Service of the New York State Society for Mental Health, reported, as quoted in the *New York Times,* that the psychiatric clinics in the state are jammed, that people who apply for help have to wait from three months to a year, and that psychiatric facilities have not kept pace with the need. One out of ten persons in our society will spend some of his life in a mental hospital, and one out of five will need some psychological or psychiatric aid in meeting his problem of living. No wonder the question arises, Why should there be so much anxiety and insecurity in our world that so many people should suffer emotional difficulties?

That is why the first part of your conference theme, "Build Mental Health," is of such crucial importance. For unless we can build health constructively, we are fighting a losing battle. Certainly no one would underestimate the necessity of our fighting mental illness—that is, helping people after they have become ill. To do this we need more clinics and more well-trained therapists to work day after day with individual persons who need help. But if we do only that, we cannot keep up with the need. We must turn our attention

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also to draining the Zuider Zee of anxiety and insecurity that cause the breakdowns.

Our society has made great progress in the battle of man versus nature, man versus viruses, germs, and other causes of disease. And for this we are all eternally grateful. But so long as man does not make progress in learning to live with himself and his fellow men, his anxiety and insecurity continue, and his illness shifts to new areas. Thus the psychosomatic and psychological kinds of breakdown have been increasingly prominent in our day. We are like Hercules in his battle against the seven-headed Hydra in the ancient tale—every time Hercules cut off one head, another grew in its place. The challenge is before us not only to help people recover from illness, but to help them *overcome their need to be ill.*

The emphasis in this address will, therefore, be on "building mental health." I shall speak on the basis of my daily work and experience as a practicing psychotherapist. But let us look beyond our clinical work and see if we can get some insight into how modern people can be helped to overcome their need to be ill and to build emotional health constructively.

When we try to understand the people who come to our clinics and consulting rooms for help, we find that their symptoms and problems are varied. Here are students who fail in school despite their high intelligence, or here are persons who cannot stick to a job no matter how hard they try, or couples who cannot love and repeatedly get divorced, or persons from every walk of life who cannot make decisions and are continuously unhappy and depressed. When we look behind these symptoms, however, we note that most of these persons are anxious, isolated, and generally lonely. And when we look even deeper, do we not find that they are persons who cannot feel at home in their world? Persons, in other words, who cannot find a basic security for their lives?

I propose the hypothesis that these people feel themselves perpetually *aliens in their world.* Therefore, they must fight each other or grasp at substitute securities in a new husband or wife, or turn to alcohol or to drugs. Many modern people suffering from emotional difficulties remind one of those drawings by Abner Dean of persons who are naked, isolated, and without belief in themselves, who perpetually ponder the

question, as they look about their world, "What am I doing here?"

We also notice in these people who come for help that they almost always have lost confidence in the values they previously believed in. And this is a very crucial point. For the distinctive characteristic of man, as compared to animals, is that he identifies certain values with his existence as a self. And when he loses these values, he loses his clear awareness of himself likewise.

This point is vividly illustrated in the statement made by Tom, the fifty-seven-year-old Irishman who happened into New York Hospital several years ago. Tom has become famous because he happened to have a hole in his stomach, made by an emergency operation when he was nine, through which one could observe the functioning of the stomach. Tom was given a job at the hospital, so that Drs. Wolff and Wolff could study his gastric functioning from day to day in periods of emotional stress. One of the important results of this study was that it demonstrated that when Tom was anxious, the secretion of gastric juices in his stomach was increased, a process that may lead, when continued over a period of time, to the formation of ulcers.

One morning Tom came into the hospital after he had lain awake all night long in anxiety, wondering whether he would keep his job in the hospital or have to return to being supported on relief. *"If I could not support my family,"* said Tom in this anxiety, *"I would as lief jump off the end of the dock."* That is to say, if Tom could not retain his feeling of being a self-respecting, wage-earning male, his life would have no meaning and he felt that he might as well commit suicide. It does not make sense to imagine, for example, a dog's refusing its food and starving because it could not feel the self-respect of knowing that it had earned the food. Yet this is what Tom is saying, and it is what many men in our society believe.

Man is the animal who does not live by bread alone. He makes certain values the center of his integration as a self. These values unify his strivings, just as the core of a magnet draws together the lines of force of the magnet. The child gets his earliest values from the love and security he experiences in his family, and as he grows, the love and esteem of

his parents become even more significant to him than physical satisfactions. Indeed, all through life the human being experiences himself as a self by virtue of the particular values he believes in. In the mature person, these values may take the form of love of one's family, belief in freedom, devotion to truth, and so on. "Give me liberty or give me death," is not mere histrionics or the statement of a neurotic, but simply the reflection of the fact that the human being places values in the center of his existence.

This brings us to one of the basic reasons why many people feel themselves aliens in the modern world—the values they believed in are in process of radical change. It is as if the culture were shifting under their feet, and what originally gave them security is no longer there. Willy Loman, the chief character in Arthur Miller's drama, *Death of a Salesman,* is secure and strong so long as he can believe that working hard and being well-liked are sure tickets to success. But when the society in which he lives changes, and when competitive striving and getting ahead of the next man no longer suffice, Willy is cast aside. Out of a job, burdened with debts, with only the pride in his previous faith to hang on to, Willy is caught in anxiety and painful bewilderment, and keeps asking himself, "How could this happen? I was the best liked!" In the culmination of his anxiety and bewilderment, Willy commits suicide. Along with losing the values he had believed in, he loses his relation to himself. As his son Biff says at his funeral: "He never knew who he was."

The picture of Willy Loman is accurate. We do live in a time when the beliefs that have been central in Western culture since the Renaissance—for example, the belief in individual competition—are undergoing radical change. We are discovering that the philosophy of each man for himself or each nation for itself no longer works. We know that we shall survive or go down into catastrophe together, but we have not yet moved into the new age of coöperation. I do not need to list for you the changes in our sexual mores, our attitudes toward work and leisure, and so on. I want only to emphasize that much of the anxiety of modern people, like that of Willie Loman, occurs because the values they believed in no longer give them security, and they no longer have a clear idea of who they are or what kind of world they live in. In such times of historical change, one has to stand on one's own feet, often

without support from the society around one. And freedom becomes a difficult burden.

The development of fascism in the 1930's in Europe occurred to a great extent because of this breakdown of values in European culture. Great numbers of people, anxious and isolated and insecure, turned to the fascist leader with his glittering promises as a way out of their insecurity and confusion. The attraction of communism in our day occurs because in these changing times the burden of free individual decision has become so heavy for many people. Hence the unfortunate increase in dogmatism in this country in these past years; if one is unsure about one's own values, one longs for some one else to tell one what to do and what to believe.

But a time of change is also a time of opportunity. Our age of anxiety is in one sense a blessing, for it makes us become aware of ourselves. It forces us to look to inner resources within ourselves and our communities. This is our task in building mental health.

Let us, therefore, look at several different areas in which modern man is an alien in his world and so suffers anxiety and isolation. First, *modern man has become alienated from nature.* We see this most clearly in his alienation from his body. In the latter part of the 19th and early 20th centuries, people regarded their physical natures as the enemy. Freud pointed out classically how people in Victorian society repressed sexual instincts, the goal being to fight one's physical nature as if one's body were an outlaw to be held continually at gun point. We would all now agree that such alienation from one's body is harmful both to physical and to mental health.

But it is just as true, though less obvious to many people, that the later gospel of release of libido also presupposes that the body is alien. Both methods use bodily nature as a machine, as if the body were an object to be manipulated. Many sophisticated people in our day know all the rules of the body, the methods of sex and birth control, and would be horrified if you accused them of repression of instincts. But their problem is often that they cannot feel—that sexual activity is so often empty and mechanical. And when we look below those symptoms, we discover that very often these people, too, live as if they were alienated from their bodies.

One of the steps, therefore, in the building of mental health

is that we recover our sense of unity with the body. Sex then becomes not an "outlet," but one expression of the person, the most intimate form of interpersonal giving and receiving. The rules of bodily health then are not ways simply of manipulating and controlling one's physical nature, but rather ways of recovering one's strength, zest, and joyful experience of the physical aspects of life. In this sense we could speak of "Brother Body," as St. Francis might have put it. In this view, a bodily ailment is not just something to overcome, it is an opportunity to learn more profoundly how to experience our bodies as parts of the self. And likewise in this view illness will be seen not simply as something that attacks the body from without and is to be overcome by various physical manipulations, but rather it will be approached in the larger context as nature's way of helping us reëducate ourselves.

Modern man has also become alienated from nature in another sense. He has tended to lose the experience of closeness to the earth, the grass and trees and other forms of physical nature. We have so well succeeded in controlling and manipulating physical nature for the sake of industrial progress that we have all but forgotten that our own organic roots also are in the earth and the natural elements. In a city like New York, we live with a wall of concrete separating us from the earth, and an almost as impenetrable wall of smog between us and the sky. I submit to you that when an individual has become so divorced from nature that the unfolding of leaves on trees in the spring and the opening of flowers have no effect upon him, something is wrong. You may accuse me of being more of a poet than a scientist at this point, but I could demonstrate to you that our roots are in nature and that when people have lost their feeling for the earth and the sky, something of the wholeness of the person is lost likewise. There is much truth in the parable of Antaeus in ancient Greece, whose mother was the earth: every time Antaeus in his wrestling was thrown to the earth, he arose the stronger. Overcoming our alienation from nature may also be a way for modern people to recover emotional strength.

Secondly, we observe that people in emotional difficulty have become *alienated from themselves.* This is shown chiefly in the fact that they have lost the sense of their own worth and cannot accept themselves. They have clung to external proofs

of their worth as selves—winning good grades in school, making a profitable marriage, getting ahead of the Jones's, and so on. As one person in therapy put it, "I'm just a collection of mirrors reflecting what others expect of me." The upshot of this emphasis on self-esteem through living up to what others expect is that one really does not have a basic self-esteem at all. Actually one's own real feelings and aims and beliefs have been lost in the squirrel-cage whirl of living up to others' expectations, and one has become alienated from one's own self.

This has much to do with the fact that so many people feel lonely and isolated. Precisely because they are so dependent on the expectations of others, they have lost their real relation with themselves. Hence, no matter how much time they spend in social relationships or running along with the crowd, they still feel empty and isolated. They are the "lonely crowd," as David Riesman puts it. And then they redouble their efforts to become merged with the crowd in the vain hope of getting over their loneliness. As André Gide pithily remarks: "Most people are so afraid of finding themselves alone that they never find themselves at all."

Building mental health, therefore, means overcoming this alienation from ourselves. What is needed may be called self-acceptance or self-love or belief in one's self, or what not; but however one names it, it boils down to the basic experience that one is a self in one's own right, and that this self is worthy and to be esteemed. This self-esteem is a prerequisite to having esteem for other people. It is the healthy kind of self-love that is a prerequisite to loving others. One of the reasons, in many cases, why therapy or counseling is valuable for people is that it gives them, often for the first time in their lives, the experience of being valued and esteemed as persons in their own right.

I should like, however, to caution against the illusion that when we overcome self-alienation, we will be free from conflict within ourselves and will then be on the rosy road to complete freedom from anxiety. I believe that the idea prevalent two or three decades ago that if one really could accept one's self, one would have no more inner conflict, arose from our mechanical view of the self, and was a corollary to our oversimplified ideas of free expression of libido.

There is no such thing as a growing, developing person who does not experience some conflict and anxiety. Normal anxiety always goes with confronting the various crises of life. But if one has a basic self-esteem, then one has a foundation on which to meet these conflicts and normal anxieties creatively. One does not feel hopelessly undermined, like Willy Loman, and one does not withdraw in the face of the conflict of growth, like the typical neurotic. The healthy self, like the healthy marriage, can tolerate a fair amount of creative conflict and come out a better person for it.

Furthermore, if we realize that we always will be confronting normal conflicts and anxiety of various sorts, *we retain the blessed virtue of humility.* The ancient Greeks believed that the strong and integrated man, like Agammemnon after he led the victorious Greeks against Troy, faced the grave danger of succumbing to the sin of pride. It was then, they said, that the gods destroyed the great man. If we accept the fact that we shall always have conflict and anxiety, we are relieved of this kind of pride. We realize that we are still human creatures who will never be perfect, and this has a remarkably mellowing effect on our relations with our fellow men. Especially is it true that therapists, social workers, clergymen, and all others who are engaged in helping other people need to guard against succumbing to pride in their own psychological "superiority." Whether we sit in the chair of the helper or of the one being helped, we are all in the same human boat.

A third characteristic of modern people in emotional difficulties is that they have become *alienated from their fellow men.* They have lost the experience of *community.* One of the odd things about our society is that there are so many words bandied about, in newspapers and over the radio and television, with so little real communication. There is so much social activity with so little real interchange of human emotions and experience among people. It is almost as if the chief rule for a success in social life were to keep one's chatter meaningless and to cover up rather than reveal one's own deepest and sincerest feelings.

This means of course that people really are afraid of one another. The continuous talk is like a filibuster—its purpose is to prevent the real issues from coming to the fore. I think

one of the conditions of our being our simple, direct selves in our society is not to be afraid of silence with one another. These points add new proof to what we have said above—that until one finds one's own self of value and worth sharing, one does not have a basis for community with one's fellow men.

In helping people in our society overcome alienation from one another, an important point is that they be able to experience themselves as *contributing* persons in the community. If, in the Middle Ages, I had been a maker of shoes and you bought a pair, I would have felt a deep and simple satisfaction every morning when you walked by my shop wearing the shoes that I had made for you—assuming that I was a good cobbler and that you wore the shoes with comfort. But in our day most workers rarely see the persons who benefit from their labor. One of the tragedies of modern society is that this simple satisfaction in producing something of value for the community becomes diluted until it is almost nonexistent. Then we place the value not on what we produce, but on the prize it brings—namely, the wages. And the goals of work tend to become not contribution to one's community, but competition to get ahead of one's neighbor.

Certainly we are not suggesting turning the clock back to the Middle Ages, but we are issuing the challenge that work be seen again in its value for the community. We need to recover the sense of the dignity of work and the experience of our being interdependent one upon another in our work. Furthermore, the growing amount of leisure time that modern technological progress affords gives us a new opportunity, which the men in previous centuries did not have, to establish bonds of fellowship in community services as well as in hobbies and play.

I am not suggesting that we construct meaningless activities in the community, as if the goal were the mere routine of "busyness" for everybody. Our task rather is to look below the external motions of work and community life to the point where we see the relation of our work to the community, and where every one has his constructive rôle to play in his work and in his relations with his fellow men. This challenge is not easily met, to be sure, and it will require imagination and human understanding on the part of employer and worker alike.

Finally, modern man has become alienated from the meaning of his life. We have already seen that one can believe in values that transcend the insecurity of the moment. Man is the mammal who, through his power of self-awareness, can devote himself to freedom, truth, beauty, and love. Thus his security in anxious and distraught times can rest on beliefs below the threats of the moment. In these days of witch hunts and character assassinations and investigations by almost every one who can get hold of a microphone or an hour on television, it is a relief to recall the figure of Socrates standing before the mob that was judging him in ancient Athens. Said Socrates to his judges: "Men of Athens, I will obey God rather than you." He went on to explain that death was preferable to giving up his beliefs, and that he could not respect himself, nor could he expect the citizens of Athens or of posterity to respect him, if he bought his life at the price of giving up what made life worth living.

It often seems to me that this is a picture of the fully integrated human being—the man who so firmly knows what he believes in that the crises and threats of the moment, even the extreme threat of death, can be met courageously. To be sure, you and I can scarcely claim the degree of courage and integration exhibited in Socrates. But the point still holds for us: we can overcome insecurities and crises to the extent that our belief in our values is stronger than these threats.

In overcoming our alienation from the meaning of our lives, the ethical wisdom of human history comes centrally into the picture. Building mental health always occurs in an ethical context. I do not at all mean ethics in the dogmatic sense of telling somebody what he should believe or how he should act. Indeed, the kind of psychiatry and psychology of several decades ago that tried to divorce itself from ethics actually turned out to be the most dogmatic of all. These were the psychiatrists and psychologists who accepted uncritically the unconscious values of the culture, such as "adjustment" to society, success, and so on. We cannot avoid assuming values in any case, so we might as well endeavor to do it consciously by free choice, and thus make sure that our values are the ones we really want to believe in.

There are in our Hebrew-Christian tradition, for example, the beliefs *that every person is to be respected regardless of*

color or race; that love is better than hate; that freedom for the individual person is a goal always to be striven for. It is by no means self-evident that these values are given in the structure of the world, despite the admirable faith of our forefathers. I submit to you that it is not easy to believe in real freedom for the individual personality, respect for every man's conscience, and real individual responsibility, in an age like ours. It is necessary that we come to our own convictions about these values; otherwise we shall not have enough confidence to stand by them when they are threatened.

In this task of building mental health, all groups in the community have their part and their responsibility. It is a very good sign that liberal clergymen are more and more concerned with understanding human personality and the mental-health problems of the community, and that more and more coöperation is occurring between the representatives of religion and the other groups working for mental health. Teachers have a very important rôle in building mental health in their students. And businessmen and labor are intimately involved in the aspects of mental health that have to do with working activity.

Mental health is never the exclusive responsibility of one profession, neither psychiatry nor medicine nor psychology nor social work. Mental health is like love—it is a goal to be striven for by every one. And though we may receive help from one another, and some persons need special care, each of us must, so far as he is able, take his own responsibility for building mental health.

Out of this distraught time a new science of man is emerging. This science includes the bodily and physical sciences and it emphasizes centrally the social sciences. It is infused with the arts of man, and it sees man in the context of the ethical traditions of human history. It is this new science of man that we hope will aid us in building mental health. This science of man can serve as a rallying point for all of the groups in the community engaged in work for mental health.

ZEST FOR WORK—GONE OR HIDING?*

REXFORD HERSEY

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"YOU'VE got to show me how you can get all of the men to work in harmony. I'll venture to say that one-fifth of my men are just plain lazy and stubborn. Now I can place confidence in the other four-fifths, and I don't have to keep on their heels, but the one-fifth won't even do the work when I'm standing over them. Now, tell me what to do in a case like that."

* This article is adapted from a chapter in a forthcoming book by the author, *The Individual in Industrial Relations,* scheduled for publication by Harper and Brothers early in 1954. It represents some considerations derived from intensive long-run studies of individual workers conducted over a period of twenty-six years both in the United States and in Europe.

The first study was conducted (1927–28) on the Pennsylvania Railroad under the auspices of the Department of Industrial Research of the University of Pennsylvania, on a grant from the Laura Spellman Rockefeller Foundation. The second was in Germany (1932–33) and was carried on with joint support of the Oberlaender Foundation and the German National Railroad System. The third study (1941–42), which emphasized the measurement of the physiological and physio-chemical reactions, was made possible through the coöperation of the late Dr. M. J. Bennett and his laboratory. The fourth study returned to the Pennsylvania Railroad (1950–53) to reëxamine the findings from the first study. It was aided by a Faculty Research Grant from the University of Pennsylvania.

Previous results have been published in *Workers' Emotions in Shop and Home,* (Philadelphia: University of Pennsylvania Press, 1932) and *Seele und Gefühl des Arbeiters* (Leipzig: Konkordia Verlag, 1935). These studies attempted for the first time to bring the methods of the clinic and the laboratory into an industrial environment and focus them on a group of workers *over a long period of time.* The workers were studied carefully in regard to (1) overt behavior, such as efficiency, lateness, coöperativeness, verbal outbursts, constructive ideas, absenteeism, etc.; (2) emotional behavior; (3) dominant trends of thought and revery; and (4) such physical and physiological items as could be either dectected or measured, such as blood pressure, blood count, colloid content of the blood, blood sugar, blood cholesterol, total androgens, metabolic rate, weight, hours of sleep, illnesses or pain, and feelings of fatigue.

The observer spent all of the working day in almost constant contact with the workers studied, and much of the time after work with them either in their homes or elsewhere, endeavoring thereby to obtain a complete picture of their whole lives. The purpose was to discover all the factors that made men happy, coöperative, and efficient at work.

The title of this article might well be, *Problems Involved in Winning Over the Lazy and Stubborn One-fifth.* On all sides to-day, one hears employment managers, foremen, housewives, and employers complaining about the unreliability of the employees who work for them. One would think that in the days before World War II one never encountered a worker who was not ready to give a completely full "fair day's work" in return for the recompense he received.

The most frightening aspect of this problem is the consequences to which this development may lead, if unchecked. With at most 10 per cent of the population in 1927–28 belonging to the "lazy one-fifth," and with this group not so poorly adjusted and disoriented as the "lazy" group to-day, the problem was then of minor importance to the nation as a whole. To-day the problem, to my mind, should be taken as seriously as our defense effort, because, if the majority of us become members of the "lazy" group and worse, America cannot fail to suffer eventually the fate of "lazy," disillusioned France, which fell so easily before hard-working Germany.

There can be no refutation of the fact that many conditions have occurred since 1929 that have caused changes in the attitudes of all of us, not just of the manual worker. In fact other foremen feel that the estimate quoted above—that only one-fifth are lazy—is on the conservative side, as the statement of another foreman on February 15, 1952, indicates:

> "I guess four out of every ten around the railroad are lazy and unreliable. They don't want the work, yet they want to make big money, and are always trying for more money, though they don't want to work. Many of the veterans tell you that Uncle Sam owes them a living and that the boss has no right to fire them when he catches them loafing. Some of them have cars and come to work in them, and they put more time in fixing their own cars than they do on the company's cars. But again there are others who are just the opposite and they prove to you the good they learned in the service and they are interested in their work and willing to make good in life.
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> "I do believe some of them are beginning to get a little better, after getting married and having more responsibility, but with others it seems to make no difference."

Even as late as August 15, 1952, however, another supervisor with wide experience, not only locally, but in other sec-

tions of the East and Midwest, was even more pessimistic. He said:

> "Sixty per cent of the new people we are hiring to-day are not worth their salt. In one shop we have ten or twelve daylight jobs vacant and cannot get the young fellows working on the second and third tricks to accept them. They say, 'Hell, no! I'll have to really work on daylight.' This attitude is typical of the youngster to-day. It is even worse with the girls just graduating from high school or business school than with the boys. They want big money on the job, but no work.
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> "The G.I.'s have a bit of an excuse. Many of them were knocked cockeyed when they had to go to war against their will. They have a chip on their shoulder. The legislation in their favor and the way the Veterans Administration has administered it have helped cause this attitude. Whatever the causes, this cancerous attitude provides fertile soil for the growth of many diseased social and economic movements, all most dangerous to the future welfare of our nation."

These comments and my own personal knowledge indicate that the problem is certainly more prevalent to-day than it was during the first study I made in 1927–28. Nothing, however, could be farther from the truth than the supposition that it did not exist in those days and, in all likelihood, throughout the history of man. Conditions existing either in the body and mind of the individual or in his social and home environment can cause him to lose any zest for work he may have had and to become a problem case.

Let us endeavor to illuminate this question further by the study of an individual worker taken from the 1927-28 study who is typical—in so far as one individual can be "typical"—of the so-called "lazy one-fifth" to-day. His reactions and the reasons for them should prove enlightening as we search for methods of "winning over the one-fifth."

Worker "#4" was a boiler-maker's helper, working in a roundhouse, unmarried, and twenty-five years old. He lived at home with his parents, but had been working since he was seventeen, having quit school after some difficulty in getting as far as the seventh grade. He had had jobs in several different industries before coming to the railroad, where he hired on as a laborer, later being promoted to helper.

Worker "#4," as measured by his I.Q. test, was the least intelligent of all the men included in the American studies. Many of the men included in the "lazy one-fifth" we are discussing are likewise below average in intelligence. Others, however, scored fairly high in intelligence. Abstract princi-

ples were for the most part far beyond "#4's" grasp. Though he went along with the study, it is doubtful whether he ever really understood the full meaning of all that lay behind it. The rest of the men were anxious to do their part in giving honest and complete information about themselves as well as they possibly could. Worker "#4" coöperated merely because he was asked to and because the others were doing it. His other relationships, both inside and outside the plant, were marked by this same lack of logical thinking. In fact he was looked upon by the rest of the workers as the clown of the shop, and his antics and his joking provided many moments of pleasant diversion that helped to make the day go faster.

Effect of Failure in Work.—The first question we shall ask is: What effect did his ability to keep his work up to the standard required have upon him? He seemed fairly keen on getting through the various jobs that were down on his work sheet, yet it cannot be said that he desired to do more than was absolutely required of him. He seemed primarily to dislike *incurring the disapproval of his boss* by falling down on the job, though, without doubt, he may have had a certain standard of accomplishment in his own mind which he desired to maintain. For on occasions when lack of material gave him a definite excuse for lying down on the job, he seldom showed an inclination to take advantage of it; in fact, usually his emotional state was, for a while at least, definitely lowered. The desire to finish a task, once he had embarked upon it, was also shown by his peevishness at being "pulled off a job without ending it up," no matter what his previous emotional tonus had been. These facts seem to offer definite evidence that the doing of his work did create positive satisfactions in and of itself.

On the other hand, why was his total average production for the year only 98.4 per cent, the lowest among all the men in the first American study?[1] Even Worker "#H," a fellow worker included in the same study, maintained a 98.8 per cent average, in spite of the fact that the amount of work he was

[1] All the workers whose production is recorded either were or had been on piece work, so that measurement of their production was fairly easy. For Worker "#4," 100 per cent production or standard indicates production at piece rates equaling his hourly wage. His type of work had been put back on day work only a few months before the study began.

scheduled to do was decreased during the year and thus he could not have been expected to come up to his agreed standard. The survey of "#4's" production record throughout the year may provide an explanation.

Not a single instance of increased production can be discovered as a result of a plant factor's operating on his emotional life, "rush of work" excepted; yet 34 periods show a decrease resulting from plant factors alone, slack work excepted. When production was above average, as a result of his emotional reactions, it was due to his high physical state or to outside causes. Yet the outside factors caused only 15 periods of increased production, as contrasted with eight of lowered, while his physical condition operated either as the single cause or as a co-factor in 44 periods of increased production and 56 of decreased.

The only plant factor that caused him to produce more than the average—and this only when he had the emotional and physical vitality to respond—was "rush of work." This was the sole cause of 13 periods of increased production and a co-factor in eight more; but "slack work" lowered production in 15 periods.

The reason for "#4's" low average for the year is now apparent. If one's standard of production is set at a fairly high mark, one must take advantage of one's periods of high efficiency to compensate for those occasions when one is forced below average. Worker "#4," however, was usually content to stop when he had produced the average amount, even though he was capable of doing much more and although the day before his production had fallen below average. In this respect the present-day "#4s" show a similar attitude, but carry it further. They do not feel the need to keep production up to standard even when they are feeling high both emotionally and physically.

Pressure and Tension.—Worker "#4" also seems somewhat unlike his present-day counterparts in his attitude toward being rushed. They are harder to "rush" than he was. If his emotional and physical condition was rather high and the rushing did not take the form of a personal "bawling out," he seemed to respond with a noticeably greater output and did not show much lowering of his emotional state. On one occa-

sion he said, "To-day was like a mad house all day. They wanted everything in a rush; too much excitement."

But his production at the end of the day was certainly 10 per cent above average, and he was not tired after the day was over. On two other occasions, somewhat similar situations, when he could not force his physical body to respond to the demand for increased production, pulled him down to a mixture of peevishness, lack of interest, and worry, which made it still harder for him to "produce." It would seem as if "#4," like the others, both dependable and "lazy," did not as a rule function so efficiently under the strain of strong emotional tension.

The source of the tension did not seem to matter much in the case of Worker "#4," whether it came from difficulties in his work, his relations with the foreman, situations outside of the plant, or other causes. As an illustration of his reactions, when, on the 18th of July, a serious accident injured another worker whom Worker "#4" did not know personally, he was sad all the rest of the day, and lost heart in his work as he pictured the situation. In the afternoon his production fell lower and lower until in the last period it was only 60 per cent of normal.

On the 14th of February, he was partly apprehensive all day over an inspection that was to take place in his military unit. His thoughts were pulled toward this crisis, and in the afternoon production again dropped off. The next day all his apprehension had vanished and he enjoyed a pleasant feeling tone. He said, "I am all ready for the inspection. I got my rifle cleaned; I know my general orders; I feel confident I can prove myself O.K." Production on this day was above average.

On the 3rd of May, he came to work in the morning feeling only fair. During the first period, he did two or three little jobs in approximately average time. At the beginning of the second period, he was put on the job of getting pipes out of a boiler. The rest of the day is a story of his lack of success with the pipes. The big outburst came at the beginning of the third period when he put his foot into the water in the boiler. After he had exploded at every one near him, he quieted down, but remained in such an excited and irritable mood all the rest of the afternoon that his efficiency on the job was prac-

tically nil; in fact, he had to leave with the pipes still in the boiler. Many of the present-day "#4s" might not even care enough to get angry. They do not fear the boss.

On the 10th of May his production was decreased in the afternoon because of the "bad humor and low pep" of his buddy with whom he was working. As his anger increased, his production clearly became lower. The same result was manifest on several occasions when he thought the foreman "bawled him out without no just cause." The only work that "#4" seemed actually to dislike was that involving the belly plate of a locomotive. Here he was forced to work in an uncomfortable and cramped position, and as a result was almost always somewhat peevish and disgusted.

Adjustment Factors.—These illustrations show how Worker "#4's" mind usually behaved under the influence of definite negative emotions which tended to draw his attention off the job. On the other hand, the opposite effect was at times noticeable when he was in a pleasant frame of mind, though these occasions were rarer than the others. An illustration of this type of response was afforded on the 17th of March, when he claimed that he was happy and enjoyed working, because he felt good, in anticipation of being off the next day, Sunday, seeing his girl, and going riding with her. His production was definitely more than 10 per cent above average, though he could easily have got by with less. His thoughts at that time turned readily and in a stimulated fashion toward his work and he enjoyed activity and accomplishment on the job for their own sakes. This happens on occasions, even to-day.

If we attempt to summarize the various factors in his work that made him happy, we cannot do better than take "#4's" own appraisal. On November 18th he said, "I can usually rate myself happy when I've got plenty of pep, the work goes good, the boss doesn't raise hell, I don't have any worries to bother me, and I am cutting up with the fellows."

Effect of His Emotional Cycle.—A careful analysis of "#4's" record, as far as it goes throughout the year, confirms his own opinion of himself. We do, however, notice the same regular variation in his emotions that we observed in the other workers. Every four or five weeks he would be low without any obvious reason. The week of February 27th provides an illustration. On Tuesday of that week he was neutral all day,

with production lower than average. He explained, "I am not exactly unhappy; I've got no worries except I wish I had more money. I am not going to get married until I have $1,000 and I am a hell of a long way from that, but I am saving a little every day."

The next day, on Wednesday, he came in neutral, dropped to anger over hitting his finger, and remained in a very irritable state all the rest of the day because he hit the same finger twice again. Production was barely up to average, though "#4's" feeling of energy expenditure was much above. He was tired at quitting time and remained that way throughout the evening. The next day he was half neutral and half peevish all day; the slightest difficulty made him fly off the handle. "I can't say why. I just don't feel right." On Friday he was still slightly below neutral. He said, "Work and outside are O.K., but still I am not just right." On Saturday he began to be more cheerful. He said, "I am much better than yesterday. I guess it's just inside me. Work and girl are all right, and I had a nice time at a party last night."

Worker "#4's" external demands for happiness were satisfied during that week, yet he was unhappy. His production was somewhat below average, it is true, but not enough to focus his attention upon it. The bosses throughout the week were very good to him and he had no exceptional worries. Something inside of him just did not seem to click. The only possible external cause would be a financial one. We find on looking back over his record that he had mentioned his financial problem during his two previous "lows." Would it not seem logical for "#4" to ascribe his low mood, in part at least, to his unsatisfied, yet ever-increasing desire for marriage? It is quite likely that this factor, though not causing it, did accentuate his low mood at this time.

It will be recalled that on February 28th "#4" said he would not get married until he had $1,000; but five weeks later, on Tuesday, the 3rd of April, he unexpectedly got married in the middle of another low phase. At that time he was getting the Sunday of one week and Tuesday of the next week off. This day happened to be his Tuesday off. From his story I could never make out exactly how it happened, other than that he felt rather out of sorts and figured that getting married would make him feel better. His marriage marked the begin-

ning of a new chapter in his relationships and will be described later.

Before his marriage, two outside influences helped to make his work-a-day world happier. One of them arose from his connection with the National Guard, while the other was the influence of his girl. The change in his relationship with her was one important factor in his later giving up his job and seeking other work. The reader may question the value of describing these outside activities so fully. I can only hope that he will agree, after studying them thoroughly, that they constitute necessary leads for the correct evaluation of "#4's" (and other "#4s' ") total adjustment problems.

The National Guard as a Hobby.—His readiness to accept authority especially fitted "#4" to be a soldier, particularly a private. Yet one would hardly have expected him to join the cavalry. He was a city boy, born and bred, knowing far less about a horse than most boys nowadays know about airplanes. Yet somehow the love of horses had got into his veins and no other branch of the service appealed to him. When the study opened, he was already serving his second enlistment. His military hobby constituted an almost undiluted source of pleasure. Drill nights gave him something to think about and anticipate as he worked. He not only enjoyed the riding and the companionship of his friends in the troop, but he admired himself in his spick-and-span uniform. And it gave him added opportunity to acquire prestige in the eyes of his girl.

Between 40 and 50 periods of the study showed the positive influence of this outside hobby, while eight periods showed a distinctly negative effect. Four of the negative periods were due to a certain apprehension, already described, over an inspection, while the others resulted because he failed to act as one of the bodyguard for some aviators who were visiting the city. Of the various experiences inducing a pleasant reaction, the one that stands out most memorably was the annual encampment at Mt. Gretna. Anticipation of and preparation for this event occupied "#4's" mind more or less constantly during the week prior to his leaving for camp. The memory of the encampment was somewhat marred by reason of the fact that "#4" sprained his back several days before he returned; but this accident did not actually pull him down after he was back at work.

There is no doubt that this outside activity of his constituted a pleasant and healthful way of spending his leisure times. It gave him stimulating exercise among congenial companions and offered his mind a pleasant diversion. However poor his plant adjustment may be rated, it would certainly seem that he had enough common sense to choose a sensible means of recreation which was in accordance with his own particular psychological make-up. Many more competent and dependable workers fail to act as sensibly. Likewise, many of the present-day "#4s."

The Girl.—Even when the study first opened, "#4" was quite in love. As far as "#4's" life at the plant was concerned, this was a very good thing. While he was in the plant, he thought about his girl and how nice she was. He often relived the times when they had been together and pictured how he would enjoy seeing her again during the coming evening.

This relationship with his girl helped to make him happier during roughly 300 periods of the study. Its adverse influence was confined to only 12 periods. On the eleventh of November, he was slightly worried all day, because his girl seemed threatened with an attack of appendicitis. But production both then and during the following day, when the worry was removed, was maintained at the average rate. January 10th, she was again ill, and this tended to pull him down somewhat. The next day he came to work "very happy, because she is all right again." He remained in the same high state all day and production responded by going 10 per cent above the average rate, at which he had kept it the previous day.

On February 20th, he came to work with his mind pretty well occupied with an argument his girl and he had had the previous evening over whether she should let the taxi man next door take her out in the afternoons and help her perfect her driving. It was typical of "#4" to think that the man was out to seduce his girl. He could not envisage the man's helping her without demanding some return for his effort. On this occasion production during both the first and last periods was considerably below average, though it is not certain that the problem on "#4's" mind was entirely responsible. His regular buddy was absent and he was working with another young worker. The society of each stimulated the other to cutting up and horseplay rather than work. The fun-making

also tended to take "#4's" mind off his difficulty with his girl.

So far we have not dwelt upon Worker "#4's" recreations other than his National Guard activities. Parties with a good bit of drinking, rides with his girl in her car, evenings with her at home or at some picture show, constituted the usual diversions he found for himself. His reaction to alcohol was usually a pleasant one, but on several occasions too much pulled him down both in emotions and in efficiency.

His chief trouble was that he very seldom got enough sleep. For this reason his life outside the shop often sent him to his work feeling so low physically that the favorable mental elements in it were completely inoperative. This is shown by the relatively high percentage of negatives listed under the physical source of crises: physical, 21.1 per cent; work, 12.8 per cent; outside, 1.5 per cent. A large proportion of the negative items assigned to purely physical causes were in the final analysis due to unwise outside activities, chiefly to lack of sleep.

The Wife.—The marriage of "#4" has already been mentioned. From the instant he was married, a peculiar change in his behavior could be noticed. No longer did he take pleasure in being the official jester of the shop; he became quieter and more dignified. Soon his attitude toward his work became more critical. Difficulties that had formerly passed unnoticed began to be extremely irritating. Jobs went bad on him more and more frequently. His outbursts and irritability were more noticeable. Such a reaction is not supposed to be typical of a newly married man and requires explanation.

If "#4" had been forced to marry his girl, one would not have been surprised, but he was not. He did, however, marry her during one of his low periods and before he had really intended to do so. His original plan had been to wait until he had more money saved up. Moreover, his physical vitality was at a rather low ebb when he married because of his habitual loss of sleep. The first few months of married life are often very exacting, with many parties to attend and new adjustments to be made. This added strain, together with his low physical condition, would seem sufficient to account for his increased irritability. No financial problem appeared until some time later—in fact, about two months after the study had closed. On one of my later visits to the shop to see

how things were going, he said, "I don't like this job as well as I did. They're always on my trail, demanding more production than formerly; and you don't get any money for it. If a man has got to work like a slave, he might as well go where he can get something for it."

On my next visit to the plant, I found that he had quit and gone to work elsewhere.

An Evaluation.—Worker "#4" represented a study of contrasting elements. Outwardly he was ever ready to play the clown, to put on the bold front and swagger with bravado across the stage. Inwardly he was shy, sensitive, terribly afraid of the unknown, and as a result often somewhat suspicious. Though he was anxious to do the work assigned him, this desire came from his respect for the authority vested in the BOSS rather than from any real interest in the job as such. He thought, however, that this authority owed him a certain return for the obedience he displayed. When it ceased to make that return, he quietly sought another authority that would give him what he thought he should have.

With his army life, the situation was different. There he gave unstintingly, with full obedience, without suspicion. There the authority was always behind him, buttressing him, or before him, leading him on. It was never struggling with him as it often was in industry.

If we may take Worker "#4" as fairly representative of the large group of "lazy" workers to-day, we may conclude from this long-run study of him, as well as from the more superficial study of many of the modern "#4s" that the following factors hold good for most of the "lazy" group to-day:

1. There is no authority in industry that they feel is truly concerned with their well-being. Why should they worry about production and conscientious application to the job when nobody gives a hoot about them? Very few, if any, actively realize any possible connection between their individual production and the ability of the economy as a whole to support a high standard of living. Somehow they have escaped learning how our complicated system of division of labor operates and the responsibility of each participant for the end result.

2. The modern "#4" has little fear of punitive action in case he does not produce his quota. The foreman is afraid to take action against him. He fears the Veterans Administration or undue union influence in the higher levels of the griev-

ance machinery, or difficulty in getting a man to replace him in a tight labor market. In Worker "#4's" case, it will be recalled, fear of action by the foreman was one of the main reasons why he usually tried to keep his work up to standard.

3. There is usually no definite, clear-cut tie-in between increased reward and increased knowledge or production. In "#4's" case, the thought of improving himself, so that eventually he could qualify as a mechanic, and the idea of a relation between his production as a helper and a promotion seemingly did not enter his mind once during the entire year of the study. To-day the group of which he is typical is in exactly the same boat. There is no relationship between promotion and proficiency in the company in which most of the studies took place. A man can bid in a job and has 15 days in which to qualify, in some instances 30, and usually, though he knows little about the job, the foreman is termed a "rat" for disqualifying him.

4. As was the case with Worker "#4," the "lazy one-fifth" to-day take no real pleasure in the actual activity of the work and no joy in accomplishment except to keep out of serious trouble. The greatest pleasure they get is out of horseplay with their buddies, breaking rules without getting caught, and loafing on the job.

5. Again, as with Worker "#4," they have no *obvious* ideals to which to appeal. Many of them, because of their unsatisfactory experiences with army life, fail to get the satisfaction out of reminiscing about it that "#4" got out of his participation in the National Guard. Had he actually been in conflict, he might, like many of the workers of to-day, have lost his sense of pleasant relationship with army authority.

6. Fundamentally, the situation is the same to-day as it was with Worker "#4." There are merely more factors—such as the great depression, the wars, the rôle of the federal government and the states through their relief activities, the increase in arbitrary protection by many unions—to bring out "#4s" than were noted in 1927–28. In those days it is likely that less than 10 per cent of the working population could be included in the "lazy" group; to-day we would normally expect the proportion of "#4s" to be between 20 and 30 per cent in the ordinary working population, where no effort has

been made to screen them out at hiring or to reëducate them after they have once been employed.

7. The problem of changing the attitude of this "lazy" group is complex. Home, church, trade union, management, and the man himself are all involved. Some of the suggestions made by older, conscientious workers with whom I have discussed this problem are as follows:

> "You say that you have a lot of confidence in the other four-fifths [this to the foreman who made the remark quoted at the beginning of this article], but that one-fifth just ignores you. This is what you should do: Split the men up and put one of the bums with a couple of the good men and make sure that the good men have a little influence over the bad one. They will be able to talk to him without him getting sore. They can show him a good example and also build you up to him, and all you will have to do is to give him a little build-up. Tell him that he is a better man since he started in to work with his new buddies. In fact, praise all three of them together, and I'll bet that you will get better results all around and the men will think more of you. These good workers are not going to let the one man ruin their good name. After that, if the lazy man don't intend to change his ways, I say then's the time to use discipline."

Another worker suggests the following:

> "If a boss has a grouchy man working for him, he seems to try his best to avoid talking to him, as he is not just quite sure what the results will be. I know myself that we have men like that right amongst us. They want the money, but not work, and they feel, 'Well, I belong to the Union; I'm going to do what the hell I feel like and let the Union take care of it. That's their headache. That's what I'm paying into it for—protection.'
>
> "I think that when the boss has a man like that working for him and he can't do anything with him, he should get in contact with the man's shop steward or committeeman and talk things over and then approach the man in a nice way and try to explain to him where he is making a big mistake, and try to give him some kind of a job that he will be interested in, and give him credit for what he does, and make him feel good and important. If he doesn't improve, after all the effort of teaching and showing him, it's better to get rid of him rather than keep him around. You remember the old adage, 'A rotten apple spoils the barrel.'"

A foreman offered the following:

> "Careful selection, appropriate job training, approbation, promotion on demonstrated merit, counseling, and disciplinary action are all involved in our winning this so-called one-fifth you speak about. Some of them are so rotten you can't expect to save them, but most of them I believe you can, but only through punishment as a last resort. The main thing is to get the community alerted to the seriousness of the problem. Let's try to

bring up the youngsters right, so that, given half a fair chance, they won't grow up this way."

These comments made by practical men who are in daily contact with the problem deserve the thoughtful consideration of every foreman and employer. They are looking at both sides of the question, although they are working with these lazy and incompetent workers whose lack of interest and qualifications for the job might at any moment cause an accident that would kill them or maim them for life.

8. The comments of the foreman just quoted seem to me to show a broad grasp of the problem. Likewise from time to time both of the two older stewards observed in the final study mention their irritation at the failure of some of this "lazy" group to carry on their share of the work. On two occasions even the youngest steward became very excited and peeved when he was very nearly hurt by careless actions on the part of the "brats" (a term for a G.I. who has used his seniority to acquire a higher-paying job for which he is not competent).

It would seem clear, therefore, that the older, conscientious workers, the union stewards, and the foremen, with the foreman giving the inspiration to the effort, should form a team that would try to rehabilitate these workers and make them into worthy citizens of industry. To-day there are too few companies that have assumed such a positive approach to the problem.

Outside the plant, not only should church and school concern themselves more directly with the problem, but the Veterans Bureau and the various state and federal relief agencies also should study very carefully the effect of their past and present methods of treating their clients. They should ask: "Are we building up morale and aiding the man to stand on his own feet as a self-supporting citizen?"

Employers and government officials should ask themselves: "Are we setting an example of honesty and patriotism that our employes may follow?"

An analysis by the author of 22 cases, asserted by their foreman to be members of the "lazy" group, indicated definite causes for their "laziness" which offered hopes for improvement in 12 cases. In five cases, the "laziness" was primarily due to physical causes; in two, to definite distaste for the type of work; in three, to the general aimlessness and irresponsi-

bility of youth; and in the two others, to outside crises and lack of any understanding or sympathy on the part of the supervisor. One man, for instance, was a Korean veteran who returned to find his wife untrue to him. His foreman told him: "Don't bellyache to me. I got more to do than coddle crybabies."

The remaining ten cases offered less tangible hopes for better adjustment. Perhaps, however, given the proper placement and training, the proper example and encouragement, careful individual study and support, and a bit of discipline, even these men might rally a spark of fair play and of native intelligence more readily than surface observation would indicate.

I close this article with a comment by Worker "#4" which, taken in conjunction with the total picture of his outside interests and loyalties, leads me to believe that, had there been such a committee made up of older workers, union steward, and foreman, to take a serious interest in his improvement, instead of his fellow workers' merely laughing at his clowning, even "#4" might have developed into a reputable and conscientious mechanic. He said, in one of his rare moments of philosophizing: "Most people, I think, have an idea of what they would like to do and be. But some folks are born happy and others are born grouchy. The grouchy ones may have everything, but still they are not happy. The happy ones may be minus many things, but they make the best of it and still keep happy. When a grouchy one works with a happy one, he gets madder and madder, because he is grouchy and hates to see the other one happy. So he finds fault with everything, though it may be right. If the bosses had any sense really, they'd take things like that into account."

HOW CHILDREN AND ADOLESCENTS VIEW THEIR WORLD

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THERE are many ways of understanding pupils: observing them all during the day; listening sympathetically to them; keeping dated samples of their work; reading their compositions about themselves and their relations with others; engaging them in informal discussions of pictures and case stories; asking them to write their three wishes; studying their spontaneous drawings and paintings, responses to incomplete sentences and stories, and other projective productions. Most of the teacher's understanding of his pupils is thus gained as an intrinsic part of teaching, not as an "extra" added to an already heavy program.

To obtain an initial understanding of a new group of pupils, one teacher spent an afternoon riding around to see the houses and neighborhoods in which they lived. Other teachers ask the nurse and the guidance worker to give them any significant information they have about the home backgrounds and family relations of individual pupils. They also study the cumulative records to gain more understanding.

In this article we shall consider only one way of gaining an understanding of children and young people—namely, by studying their freely written compositions. Unsigned, spontaneous compositions give us some understanding of how pupils are thinking and feeling about the conditions in which they find themselves; we get glimpses of their inner world and are helped to see things from their point of view.

It is important that we be able to see things from the pupil's point of view; the way a pupil sees a situation or looks at his world determines to a large extent what he learns and how he behaves. In the phraseology of Gestalt psychology, a person responds to the "situation-as-perceived." His behavior is determined by his own perception of the situation at the time. Suggestions made by an adult are most effective when they

take into account the pupil's point of view. Moreover, a teacher who sees a pupil in a different light because of increased understanding of him, behaves differently toward him.

Compositions can be obtained in the course of regular classwork in English or guidance. Pupils welcome an occasional opportunity to write about themselves. This kind of writing releases tension and helps them to view their feelings more objectively. Some pupils respond more freely in anonymous compositions than in face-to-face interviews.

Topics such as the following may be suggested: "If I had three wishes, what would they be?" "The kind of person I really think I am; the kind of person I want people to think I am." "What I've liked about my teachers; what I've disliked." "How I feel when I take my report card home." "How I feel about growing up." "Times when I have felt 'at a loss,' 'all at sea,' or disturbed."

Two cautions must be given about the use of this method: It should not be overdone; pupils can get tired of writing subjective compositions. Second, the teacher must be careful never to identify in class any individual pupil's statement, or to laugh about any composition in class or with other teachers. Common problems revealed in the compositions can be discussed in class or used as the basis for rôle-playing situations; pupils can be helped to take serious personal problems to the school counselor.

Now let us read some compositions to see how pupils in different parts of the country feel about school, teachers, report cards, social relations, family relations, and themselves as persons.

What They Think About the Curriculum.—High-school pupils have many suggestions for improving the curriculum. Boys who have gone into officer-training programs in the armed services have appreciated good stiff courses in mathematics. Others advocate more shop courses; many suggest school experiences that would help them "to speak better and more clearly," to gain a wide knowledge of current affairs, to improve their conversation, and to get along with others. Some want try-out experiences, so that "you can learn what you would excel in and what you wouldn't be able to do."

What They Think About Methods of Discipline.—Different pupils react very differently to what seems to us to be the

same treatment. For example, a sensitive child in kindergarten, scolded in front of the class for whispering, cried all night when she got home. "In fact," she later wrote, "I was so terribly unhappy that my mother came to talk to the teacher." Many gifted children, bored by the school program, "take to conversing with neighbors, for lack of anything else to do."

Pupils recognize that limits are necessary. One ten-year-old wrote, "I like Mr. E. because he won't let you fool around as much as the other teachers do. He is strict, but always ready for a laugh." Lack of definite limits on behavior often makes children feel insecure and anxious. They need adult help in doing the right thing; they feel successful and happy when they have met the demands of school and society.

What They Think About Teachers.—Children often understand teachers just as well as teachers understand children—in some cases, better. They are very fair-minded; they realize that teachers are human. "I like my fifth-grade teacher when she gets up on the right side of the bed," wrote one pupil. They also realize that a roomful of youngsters can be quite aggravating at times. Most of all, they appreciate teachers who like children and who are kind. A sixth-grader in a rural community wrote, "My first-grade teacher was a very old woman who had never been married. I liked her because she liked children a powerful lot."

They are very sensitive to teachers' fairness: "She did not have any one child who was her pet." "She always found a way to use pupils, even dumb ones. She would make them feel at home and that they were welcome." They want teachers who are helpful and encouraging. One seven-year-old wrote, "When you did your work, she never hurried you. She always smiled and whispered, 'You're doing good.' I think she loved us."

How They Feel When They Take Their Reports Home.—Many take their report cards home with fear and trembling. Some are even afraid to go home. This is because parents tend to scold or punish them, or deprive them of privileges. Often parents merely tell them to do better without giving them any specific help in making more progress.

How They Feel About Growing Up.—Children in the elementary school often describe a fanciful future in which get-

ting married plays a prominent part. For example, one nine-year-old girl wrote:

> "I want to grow up fast so I can go to high school, then I am going to take up typeing, and then when I get bigger, I can be a secretary for awhile. Then I am going to get married and have two children a boy and a girl and we'll live on a ranch in Texas. We'll have horses and ponys for the children and we'll have cattle and a donkey and dog and a cat for the kids and when they get old enough they'll learn how to ride big horses and they'll look like cowboys because they'll be wearing cowboy boots, shirt, pants, and play guns, and a cowboy hat."

Pupils in the first year of high school often look forward optimistically to being on their own, though some recognize that the future holds both happiness and unhappiness. A girl in the tenth grade had quite a definite view of growing up:

> "I feel that growing up is something that must be. A person can't remain a child all his life. A person must look forward to greater things in life, such as: getting a good education, training your mind so you can be able to get a good job that has a future in it. A girl has to think of getting a good job just as a boy has to, because she cannot expect to just go and get married right away so that she doesn't have to work.
>
> "When I graduate I expect to become a secretary. I would like to be a lawyer's secretary because it may prove to be exciting. I like excitement, so wherever I can get it, that's where I will be more apt to go for a job in which I will be satisfied.
>
> "I also think that when you are growing up you should decide in advance as to what you would like to do when you get out of school, so that when choosing what course to take, you choose one that is beneficial to you."

Seniors often show serious concern about their future—the draft, finding a vocation, establishing a family of their own. A senior high-school boy wrote as follows:

> "There are many problems for both boys and girls of high-school age. When you think about it you don't even know where to start. Nowadays high-school kids have to grow up too quick with war facing them and also our future jobs and goals. There are many other problems which some might consider very important and others not.
>
> "There is also the problem with the parents when they tell you to do one certain thing when you think that if you do it the other way it is much better for you. But one of the biggest responsibility is when after graduation you are practically on your own and you face the future and know you're on your own."

How They Feel About Social Relations.—Boy-girl relations are of great concern to adolescents. One girl who had been unpopular during the first three years of high school wrote: "If someone had only helped me during those first

years of high school, I would not have cried myself to sleep so many nights." Many write about problems of dating—how to get a date, how to behave on a date, how to persuade the family to let them have the car and stay out late. "Every time I want to go some place," one seventeen-year-old girl wrote, "the whole family wants to know where I am going, who I am going with, and if I want anyone to come for me."

How They Feel About Family Relations.—Many of the compositions reveal poignant problems:

> "When I was sixteen I had a problem of having to face the fact that my mother and father were going to separate. This was something I couldn't do a thing about. The fact of my loving them both and having to be separated from my father hurt me more than anything in this world."
>
> "My greatest worry is my grandmother. I love her dearly, and it broke my heart when my mother married again and we moved away, leaving my grandmother behind."
>
> "I feel very left out in family affairs. I have a sister who gets everything she wants. If she and I want to go out the same night, I must stay home with my baby brother. My mother puts all the responsibilities on me."
>
> "My father is quite sick and cannot work. My mother works at night and I take care of my little brother."

How They Feel About Themselves.—A person's concept of himself is a prime determinant of his behavior. Skillfully introduced by a person in whom the pupils have confidence, the simple question "What kind of person do you really think you are?" evokes significant responses. For example, one eighteen-year-old girl wrote:

> "I don't consider myself perfect, I know I have many bad points. Though I have good ones. I think I'm considerate of others and I like to help people in need. I'm not too loud, but sometimes silly, and when I start talking to someone if the conversation interests me I talk too much. That's because I like discussion, say like in history or political questions. I'm lazy at times, though I try not to be. I'm usually friendly with those who are friendly, otherwise I keep by myself. I want to succeed in something, but I'm quite mixed up and can't understand really why I keep thinking about this question a lot. Besides I do a lot of thinking if I feel disgusted with something. Otherwise I'm very happy if people make me happy and everything is O.K."

In replying to the second question, "What kind of person do you want other people to think you are?" pupils often show a lack of self-acceptance and a desire to appear different from what they are.

These are just a few glimpses of the inner world of some children and adolescents. Any teacher, spending an hour reading similar compositions written by his own class, would gain a most rewarding understanding of their personal worlds of meaning and feeling. Whether or not the pupil's world corresponds to reality as we see it, his perception of it, along with all the other information a teacher has about him, is an important source of understanding.

WHAT IS MENTAL HEALTH IN A UNIVERSITY? *

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I CAN think of no greater pleasure than to be here, on the occasion of your University of Nebraska Mental Health Institute, to help inaugurate, and to see in action, a first-class program devoted to the furtherance of a side of education that has been largely ignored in the past. The fact that a major university has taken upon itself the task of training its students in the realm of feelings and emotions as well as in matters intellectual, is a cause not only for hope and gratification, but for congratulations as well. Whether we live together in this world in peace and harmony, or destroy ourselves by hatred, aggressiveness, jealousy, or frustration, is a matter of utmost concern. Where is there a better place than in an educational institution such as this for learning to understand one another, mastering the give-and-take methods of democracy, and devising ways and means of removing obstacles to good living without destroying the social structure itself?

Sir Richard Livingstone, in his recent discussion of "Education and the Spirit of the Age," [1] stated that our present-day education is defective in that it lays too exclusive a stress on analysis. As he says, a stock injunction to teachers is, "Teach the pupil to think. Give him a critical mind." While he admits that this is of immense importance, "to teach people to see and feel is more important still." "The best way to make a person critical is to show him the first-rate till anything inferior ceases to attract." Or again, "In every one the poet should keep company with the rationalist: then we have the highest type of educated man."

* Revision of an address given at the University of Nebraska, Lincoln, Nebraska, March 20, 1953, on the occasion of the inauguration of a mental-health program for the university.

[1] *Education and the Spirit of the Age*, by R. Livingstone. New York: Oxford Press, 1952.

My chief object to-day will be to discuss the "poetic" element of education in contrast with the rational, though possibly in a slightly different sense from that which Sir Richard had in mind. The alteration of meaning will not be violent, however; my colleague, Dr. Herbert I. Harris, has frequently stated that a chief purpose of psychotherapy is to enable the patient to become "the poet of his own feelings." If an education is the ability to read, write, speak, and listen, I should like to present the reasons why the ability to understand feelings should be added.

Before considering mental health we might set the stage by introducing the concept of health in general. Health is not simply the absence of disease, but, in terms of the World Health Organization definition, it "is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

In the same vein we think of mental health—namely, as a state of mind that permits full and satisfying participation in whatever life has to offer. In terms of student experience, it enables the individual to take the greatest possible advantage of the academic, extracurricular, and environmental offerings of the university. Therefore, it is not something new to be added to an already overloaded curriculum. It is not a technique, a doctrine, a limiting factor, but, instead, it connotes freedom, responsibility, flexibility, and self-reliance. It is, therefore, a vital aid to traditional education, enriching both it and those who participate in the teaching process, the teacher and the student. It is everybody's business.

Mental health is still thought of by many persons as the absence of emotional or mental illness. This idea has sound historical backing. The mental-hygiene movement in this country—which had its formal beginning in 1908, when Clifford Beers was instrumental in forming The National Committee for Mental Hygiene—was largely devoted to the purpose of improving the care and treatment of persons confined to mental hospitals, or asylums, as they were then called. Like Robert Hutchins, when he introduced Albert Schweitzer to his audience at Aspen, Colorado, in 1949, with the words, "We who are well need him even more than those who are sick," so we may say that mental health is more of a concern of those of us who are outside institutions than those who are

within them. Mental health is a difficult concept to define; it is elusive, subject to unhappy exploitation by quacks and opportunists, but none the less rather simple. The trouble is that its principles call for action that is selfless, and at times sacrificial, and they are, therefore, hard to practice.

The individual who is well adjusted, in the words of The National Association for Mental Health, feels comfortable about himself, feels right about other people, and is able to meet the demands of life. He guides his emotional expressions, is tolerant, has a good sense of humor, respects himself and other people, is responsible, can relate himself to other people, and gets satisfaction from what he is doing. Perhaps Dr. George Preston summed up these qualities in the neatest and most witty form when he said that mental health consists of the ability to live: (1) within the limits imposed by bodily equipment, (2) with other human beings, (3) happily, (4) productively, and (5) without being a nuisance.[1]

To admit the desirability of mental health in the individual is like accepting the idea that a balanced diet is a good thing, or that evil is undesirable, or that love is a better emotion than hatred. Its attainment in the individual is made much easier or much harder depending upon the person's own past experiences and on his present environment. The past cannot be changed, but one's reactions to it can be. Fortunately, our environment can be improved if we can decide on what should be done and how to go about doing it.

Not the least of the functions of a mental-health program on a university campus is that of pointing out to all members of the community the main obstacles to the attainment of mental health as far as the individual is concerned. Those of us who study the problems of students who come to us for aid are impressed repeatedly with the frequent, almost monotonous occurrence of a few general situations or conditions. Among these are parental friction, which may or may not involve divorce; lack of warm feelings and of emotional flexibility in parents; inconsistent or punitive application of discipline; distorted or squeamish attitudes about toilet and sex activities; and poor neighborhood environment. At times the young person has not had suitable objects of identification

[1] See *The Substance of Mental Health*, by G. H. Preston. New York: Rinehart and Company, 1943. p. 112.

because of lack of adequate masculine characteristics in the father or of feminine attributes in the mother.

The fact that these primary difficulties recur so often suggests that we, as college students, should plan the home we hope to establish with the idea in mind that these hindrances will be minimal. This is not to suggest that the growing child should be protected from the normal stresses and strains of growing up; rather it indicates that the ability to withstand hardship and conflict is vastly increased when home influences are good, and when the child can count on his relationships there with considerable certainty. As Santayana has said, the mind that has a good ballast can withstand a large portion of madness.

One of the main difficulties faced by those who are interested in improving parental attitudes toward children has been the lack of ability to present the proper facts without making the parents feel threatened, inadequate, or insecure themselves. Somehow, in such a mental-health program as this one, we must learn the technique of communicating the principles of mental health without letting them become threatening or instruments of derogation. In medicine we are accustomed to deficiency diseases. For instance, lack of vitamin C gives rise to scurvy and lack of vitamin D causes rickets. It is just as clear to those who work with children that a deficiency of affection, of consistency, or of kind, but firm discipline gives rise to psychological syndromes that are just as harmful, even though less well defined, than those due to lack of vitamins in the diet. It seems logical, therefore, that we should plan the child's environment with as much care as we plan his diet. The difference, however, is that the diet can be bought with money, but the psychological environment requires continual thought and planning, with a great deal of self-discipline as well.

Mental health in a university has a great deal to do with teaching and learning, with emotional blocks to learning, with how teacher and student interact with one another. Does the faculty member think of his students as living, feeling, developing human beings, with an infinite variety of approaches to the problem of attaining maturity, or does he think of them as willing or unwilling receptables into which a certain amount of knowledge must be poured? Do his teaching

methods incite curiosity or rebellion? What are his attitudes toward himself and his relationships with others? Can he look at himself, evaluate his own strengths and shortcomings, and still feel secure enough to say, "I don't know," when he does not know, or to deal with highly speculative or controversial material with confidence? Along these lines Sir William Osler thought in terms of the teacher aligning himself on the same side of the material as the student. Nearly fifty years ago he said:

> "The successful teacher is no longer on a height, pumping knowledge at high pressure into passive receptacles. The new methods have changed all this. He is no longer *Sir Oracle*, perhaps unconsciously by his very manner antagonizing minds to whose level he cannot possibly descend, but he is a senior student anxious to help his juniors. When a simple, earnest spirit animates a college, there is no appreciable interval between the teacher and the taught—both are in the same class, the one a little more advanced than the other. So animated, the student feels that he has joined a family whose honor is his honor, whose welfare is his own, and whose interests should be his first consideration."[1]

Mental health on a campus concerns itself with the attitudes of students and faculty members toward one another. The field of student counseling might be considered as an example of how necessary it is that those who work in it have mature and understanding attitudes toward one another as well as good understanding of themselves. Specifically, counseling of students may be done by psychologists, psychiatrists, vocational-guidance experts, social workers, ministers, coaches, and teachers generally.

If any one group assumes a vested interest in this field, assumes that it has the answers, and then becomes unnecessarily critical of others, the program suffers. One of my colleagues has said, "I have noticed that the person who does not feel rivalry toward others seldom notices rivalry from others." The field and the need of counseling is so great that empire building is not in order. In fact, I believe that the main portion of student counseling should be an integral part of the total relationship between the teacher and the student, and hence integrated with the intellectual relaionships for which a college exists. Obviously, this point of view presents certain dangers. Is the ordinary faculty member equipped to do

[1] See *Selected Writings of Sir William Osler*, edited by G. L. Keynes. New York: Oxford Press, 1951. p. 173.

counseling effectively? May he not try to become a therapist, and hence let himself in for the dangers of all persons who work in fields for which they are not prepared?

I do not believe that the dangers of widespread counseling by faculty members are very marked if certain definite principles are kept in the foreground. The skills that are desirable are not of such a nature as to narrow the range of action of the counselor, nor do they stamp him as belonging to any particular school of thought. Some of the principles that, in general, influence the counselor's attitudes are as follows:

1. The chief function of the counselor is to help the student formulate his problem rather than to solve it for him.

2. Direct advice is usually not given; instead, the student is aided in discovering and weighing the alternate courses of action in a given situation.

3. The apparent situation that brings the student to seek help may not be the problem that concerns him most. He may not wish to divulge his chief concern until he is sure what reception he will get, or he may not be fully aware of what bothers him most.

4. The student's thoughts and behavior are considered objectively without the exercise of judicial functions of any kind during interviews, though the student may at times be encouraged to exercise judgment.

5. The counselor avoids probing into the student's private and personal affairs, but lets him divulge what he chooses in his own way and at his own rate. The counseling relationship continues even when the student is under professional care.

6. The counselor is under no obligation to help every student who comes to him or to find a solution to every problem. For many situations, there are no satisfactory solutions and a sensitive and intuitive understanding is about all that can be offered the student.

In addition to the fundamental job of the psychiatrist, the psychologist, the vocational counselor, or other professional person, of working with the individual student on some aspect of his growth and development, there is another equally important function of an educational nature. Some one has said that psychotherapy is education and education is psychotherapy. Certainly, each process has many features of the other. Psychotherapy of the seriously disturbed patient might

be thought of as one end of a spectrum and the educational process of the completely normal person—if there is such—as the other. Along this broad band the development of insight, skills, abilities, and all kinds of characteristics proceeds in the general direction of maturity, intellectual, emotional, and social, unless there is some interference. At one end of the band the teacher presides, and at the other, the psychologist, the social worker, or the psychiatrist performs his functions.

The basic goal of a college mental-health service is to organize the knowledge of human beings, as formulated by the psychological sciences generally and from therapeutic experiences with students specifically, in such a way as to make it useful to the teacher in his enormous responsibility of aiding the optimum development of the student. By verbalizing and understanding the main obstacles to the attainment of mental health in the individual and delineating the positive principles of mental hygiene, which psychiatry should be able to formulate, it is hoped that a larger portion of the spectrum can be supervised by the faculty member and that thus a correspondingly smaller burden will fall upon the professional in the field. In other words, the professional should devote his energy toward the end that his own services will not be necessary.

It must be conceded that not all good teachers are temperamentally suited to be counselors. Some may have duties so pressing that they cannot spare the time that is needed. The influence of others on students may not be wholly desirable. It should be remembered, however, that the primary purpose of an educational institution is the training and education of young people, and that research and public service exist in part to broaden and deepen this purpose. Hence, any contact between a faculty member and a student becomes in one sense a counseling situation, good or bad. The teacher who is aware of his own capacities, of the effect he has on others, who understands other people, and how they feel about matters of little and great import, is in a position to exert an influence for good on his students far out of proportion to the time spent with them.

A faculty riddled by feuds, by jealousies, by insecurity, and lacking in deep purpose, communicates these attitudes to students more readily than if its members deliberately taught

harmful concepts. The result is low morale of students, ethical short-cuts, the acting out of problems in the form of antisocial behavior—a mirroring of the principles they see in action.

I think it a reasonable statement to make that the teacher who develops the counseling attitude, who tries to take into consideration the host of factors, conscious and unconscious, that influence learning, not only becomes thereby a better teacher, but helps himself as much or more than he helps his students.

One of the chief problems of the college student is the attainment of independence or emancipation from his parents in such a way as to retain their friendship and respect, as well as to feel that he has established himself as an independent person in his own right. If he comes to college and finds that he is still treated as a child, that he is hemmed in with restrictions and rules, and that he is not trusted, then he will react exactly as he would at home, by rebelling or by some other equally unsatisfactory type of activity. The college environment is then simply a dilution of his home environment, with most of its disadvantages and but few of its advantages.

The principle that abrupt use of authority invites resistance has been known probably as long as teachers and students have thought about their respective rôles. Dr. Franklin Carter, himself a president of Williams College, once wrote of one of his predecessors, Mark Hopkins, who was president from 1836 to 1872:

> "Dr. Hopkins was not a believer in rigid rules. . . . He depreciated that antagonism which rigid and minute rules were, he thought, sure to engender. He believed fully in the general influence of a faithful and earnest body of teachers, and thought that young men could be far more effectually guided to true manliness by an example of kindness and patience than by formal restrictions or constant intimations that they were under authority. He was . . . equally opposed to any very definite system of penalties. It was offensive to his ideas of proper training to treat all students in exactly the same way. His conviction was strong that all students are not precisely alike in their training or tendencies, or abilities."[1]

I might add that many members of the Williams faculty strongly disagreed with the basic philosophy of Mark Hopkins,

[1] See *Mark Hopkins*, by F. Carter. Boston: Houghton Mifflin Company, 1892. p. 80.

and once when he was out of town on a speaking tour, they passed a particularly drastic rule concerning absences, resulting in the famous "Rebellion of 1868," in which all but three students withdrew from all college exercises. On his return, four days later, Dr. Hopkins succeeded in effecting a compromise, resulting in a return of the students and a general saving of face all around.

A permissive attitude toward individual variations from acceptable behavior and good taste, coupled with firm, but kind insistence on higher standards, is not an easy thing to achieve on a college campus. Too much freedom and responsibility may not be well handled by young undergraduates, or may even be the source of anxiety. The younger members of the community must realize that there are limits beyond which one cannot go without penalty. As Judge Learned Hand has so well stated: "A society in which men recognize no check upon their freedom soon becomes a society where freedom is the possession of only a savage few."[1]

This suggests, therefore, that responsibility must go hand in hand with freedom. A climate of opinion must be generated which permits some deviant behavior from the social limits set by the community, but not enough to injure seriously the community and its standards. In short, a strong student government, backed solidly by informed student and faculty opinion, is one of the strongest possible educational instruments of the university community.

We are all well aware of many relationships between athletics and health, and how each contributes to the other. Even more important in the development of good mental health on a campus is the question of how and for whom athletic activities are planned and accomplished. I refer particularly to the acute question of the subsidization of athletes while in college.

I have recently been told that several administrators of athletic activities have been concerned as to the effect on the subsidized student of handling him a check or money once a month, compensation which cannot be freely admitted, and which is acquired in a manner remarkably similar to undercover deals in dishonest politics. Does this increase the student's sense of responsibility? Does it help train him to be

[1] See *The Spirit of Liberty*, by L. Hand. New York: A. A. Knopf, 1952 p. 190.

on the lookout for graft in the handling of public affairs? Or does it cause him to detect insincerity, and value honesty and integrity? The questions answer themselves, but it takes more than intellectual conviction to stand up to the pressures of those groups who demand winning teams at any price.

Gresham's Law states that bad money tends to drive good money out of circulation. Certainly there must be a similar principle at work in colleges and universities in which sharp practices in athletics tend to crowd out desirable ones. Mental health in a university does concern itself with athletics for all students who wish to participate, and with how they shall be administered. When athletic directors, faculty members, college presidents, and alumni unite in demanding no special favors for any one group of students over another, we shall have made a real start in attaining maturity.

Since colleges and universities are under strong attack from many quarters at this time, it is one of the responsibilities of those interested in mental health to study the influences at work that promote or hinder freedom. Some new factors seem to have entered the thinking of our people, something that is influencing our usual concepts of public morality in a profound way. Loyalty to the basic principles that have governed American thinking since the formation of the nation seems to many in our country to be something different from what the rest of us had supposed it to be. Pressure groups with rather nationalistic and selfish ends in view have demanded agreement with their views, and for those who do not agree, the price to pay is that of being denounced as "disloyal." The simple principle that any individual is presumed innocent of wrong-doing unless he has been proven guilty has been replaced in some measure by the concept that if some one has made accusations against another, then that person must have been up to something improper. Clearing of one's name after such charges does not serve to repair the lasting damage that has been done by the publicity of the accusations. Association with others, whether in the past, accidental, or even on an involuntary basis, is being increasingly used as a means of impugning loyalty. Suspicion of the colleges and universities, always present at least in a latent form, has been encouraged in such a way as to suggest that they are "hotbeds" of subversive teaching. From all this there has naturally

arisen the fear on the part of many teachers, as well as students, that if they express opinions on political subjects or about politicians, they will later be subject to reprisals.

In such an atmosphere of doubt and suspicion, in which the accuser does not have to face the accused, the informer tends to become overpublicized and possibly overpraised, thus furthering the tendency for people to spy on one another. This tends to break down our mutual confidence in one another, the very fabric that supports our democratic society. As President Killian of M.I.T. has phrased it, "You cannot build America up by tearing Americans down." [1]

Freedom has never been easy to attain or to keep, and as we see it threatened in so many ways, we need to mobilize resistance to all those who would deprive us of it. It is not a simple question. It will not be easy to solve, and anger and dismay are of no help. What is needed is a deep, sober consideration on the part of all of us of the significance of the changes that are taking place daily around us, followed by a strong determination to point out the dangers and suggest possible remedies before it is too late.

In colleges and universities those who are working closely with students are well aware that they have an infinite variety of difficulties to overcome in their efforts to get the most out of their years of formal education. That students, like all the rest of us, need help from time to time, is obvious. Whether it is a proper function of a university to aid the student in securing that help is a matter of policy, with some of us believing that it should, and others, possibly a majority, believing that treatment of illness is outside the domain of an educational institution. The latter point of view in the field of mental health has at times been expressed in some such form as this: "A student is either well or he is not well. If he is sick enough to need the services of a psychiatrist, he is not well enough to remain in college. Therefore, there is no need for a psychiatrist in an educational institution."

Important as we may consider the treatment of sick students, that is not the area in which the psychiatrist may be of greatest usefulness to a college. At the same time the fact cannot be dismissed that from experience derived from the treatment of students the necessary background and knowledge are

[1] In his address to the graduating class, M. I. T. Commencement, 1953.

obtained that are so necessary in working effectively with student-government officials, counselors, faculty members, and the administration. If there is but one psychiatrist connected with a large university, he is always faced with a serious dilemma as to how he shall divide his time in view of the overwhelming demands made on him. If he sees students exclusively, the broader educational aspects of his program suffer. If he sees too few individual students as patients, his firm foundation of knowledge and experience becomes weakened, and the educational program will seem thin and artificial. An approximately equal distribution of time between these two aspects of his work is probably a desirable goal.

But what is the educational aspect of which the college psychiatrist talks so much and whose principles he values so highly? A primary responsibility is to help develop the idea that there is far more to education than the pure development of the intellect. The emotional concomitants of learning are as basic as the material itself. From this it follows that how one feels about oneself, about others, about one's subject matter, and what one's motivations are, may make all the difference between the sterile, unimaginative, pedantic person and the warm, considerate, sensitive, self-reliant one who is creative and capable of implementing his knowledge.

In some institutions the representatives of it are said to be charming and agreeable when they want something from a visitor, but cold and discourteous in manner when the visitor wants something from them. Students notice similar behavior in university employees and react to it by criticism, hostility, or anxiety, but if the attitudes are friendly, they react with friendliness. This is a concern of mental health; their attitudes show through, and such attitudes are a proper concern of the psychiatrist.

Those who practice psychotherapy are frequently as unable to explain improvement in some of their patients as they are to understand why others do not improve. Frequently the answer to either of these questions lies in the way the two individuals react upon one another. The therapist may influence the patient as much by what he is, and by what he represents to the patient, as by what he does to him. Similarly, the teacher, in the classroom or in his less formal contacts with students, may influence them out of all proportion to the bare

recital of what was seen to go on. As Sidney Hook has recently pointed out,[1] the teacher is frequently unaware of how much he may influence the life, ideals of conduct, standards of judgment, secret ambitions and hopes, or even the choice of a life career, of his students.

Whatever else he may do, however, he must try to make himself dispensable, so that the process of education, once begun in college and earlier, may become increasingly autonomous. As Hook emphasizes, to develop this capacity for self-education in his students the teacher must aim for emotional and intellectual maturity.

Emotional and intellectual maturity are essentially one, in the same sense as mind and body are one. Hook's observations on maturity are so fundamental that a further consideration of them is quite enlightening. To him, emotional maturity connotes the *habit of reasonable expectation,* not a course of blind optimism or hysterical giving in to fear or apathy. Knowledge of things is not sufficient to achieve it. It seems to depend more upon knowledge of self and others, upon historical perspective and "an awareness of how the best of men fall far short of their own ideals. It is acquired slowly, cannot be forced, and, like most virtues, is more likely to be achieved by indirection."

"Intellectual maturity," on the other hand, "is manifest in the capacity for reasonable assessment of evidence." The mature person does not assume that knowledge in one field carries over into another. His thinking varies, depending on the field of interest. It is effective "only when it reveals command of subject matter." It implies respect for, but not worship of, facts.

Mental health is concerned with discipline and preferably the kind that the individual exercises on himself, not the punitive variety. The more the whole problem of individual deviations from acceptable behavior can be handled by the students themselves through a responsible student government, the more likely it is that suitable behavior will be taken for granted.

Discrimination of all types likewise falls under the scrutiny of any one interested in developing the highest type of value

[1] "The Job of the Teacher in Days of Crisis," by S. Hook. *The New York Times Magazine,* December 14, 1952. p. 9.

judgments which we may identify as an expression of mental health. Possibly a chief function of education is to enable the individual to exercise intelligent discrimination in favor of the good, the beautiful, the first-rate in all fields, but certainly education has failed in its mission when those who think they have it prejudge individuals without knowing anything whatever about their personal characteristics. Our discriminatory practices in this country are among the greatest hindrances toward our developing any real moral and spiritual leadership in the world. As the song, *You Have to be Carefully Taught,* in *South Pacific* suggests, intolerance has to be taught early if it is to be really strong. Tolerance may perhaps be a more natural trait than its opposite.

Sometimes curious customs arise in our colleges that have long-term effects of unexpected nature. Medical-excuse systems frequently lead to gross exaggeration of illness when secondary gains are needed. Using required attendance at all class exercises as a punishment may suggest the opposite idea from the true one—the idea that the chief privilege of going to college is going to class. Many customs in the management of laboratory sections result in practices that strongly suggest plagiarism in that it is well known that solutions are always kept on file in various student centers all over the campus. Many probation systems are designed to limit further a student's social contacts when his interpersonal relationships are already seriously disturbed. In these and many other similar fields, we can see room for improvement through thoughtful self-analysis.

We emphasized earlier that the college sometimes appears to the student to be a diluted version of home. In many ways this is desirable if those conditions that perpetuate dependence are minimized and those that develop independence are encouraged. From the standpoint of developing an environment in which true maturity can be attained most readily, we need good communication at all levels in the university, from faculty to student, student to student, and student to faculty, thus engendering the feeling of belonging. Communication between members of a very large heterogeneous group is very difficult and hence small groups have to be developed in which meaningful relationships for individuals can be encouraged. A permissive attitude, with much tolerance of individual eccen-

tricities, is desirable, but it must be accompanied by a climate of opinion that fosters real discipline—namely, that which is self-administered. The individual should always be considered, but whatever concession is made to personal situations should not result in any lowering of academic or ethical standards.

If Sir Richard Livingstone is correct in his assumption that continued exposure to the first-rate results in dissatisfaction with the inferior, then we in the universities should be satisfied with nothing less than the best in true mental health on our own home grounds.

TRAVELING COMMUNITY-MENTAL-HEALTH CLINICS: THEIR EXTRA-THERAPEUTIC ASPECTS AND FUNCTIONS

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THIS paper was conceived as a complement to two other papers that have been published from this center on various functions and aspects of traveling community-mental-health clinics. One of these, by Drs. Coleman and Switzer,[1] described the treatment process in this type of clinic; the second, by Miss Thaler,[2] the work of the psychologist in such a clinic.

The aforementioned papers dealt primarily with the treatment and diagnostic psychological testing functions, as well as briefly with the development, of traveling community-mental-health clinics in Colorado. It is our intention to consider in more detail the no less important extra-therapeutic functions and responsibilities of a traveling community clinic. These relate to consultation, clinic-community relationships, in-service training, community education, and community planning.

Mental-hygiene clinics had their beginnings in the second decade of this century. Their original purpose was to reduce the number of admissions to state institutions, and for this reason they dealt primarily with very sick adults and delin-

1 "Dynamic Factors in Psychosocial Treatment in Traveling Child-Guidance Clinics," by Jules V. Coleman and Robert E. Switzer. MENTAL HYGIENE, Vol. 35, pp. 386–409, July, 1951.

2 "The Rôle of a Psychologist in a Traveling Psychiatric Clinic," by Margaret Thaler. MENTAL HYGIENE, Vol. 34, pp. 219–27, April, 1950.

quents. These early clinics also had an educational aim—that of changing the hopeless, fearful, condemning attitudes of the public toward mental illness.

In order to carry out this purpose, the early workers felt that they had to reach the more outlying communities, and thus traveling mental-health clinics came into being. When further study of mental illness seemed to indicate that its origins frequently lie in the years of childhood, mental-hygiene clinics became interested in work with children, in the hope that future mental illness could be detected at this stage and averted by early treatment. From this there was a gradual shift toward an interest in promoting mental health for its own sake. This development is very ably traced in the books by Stevenson [1] and Witmer.[2]

It is our belief that a dynamic psychiatric orientation of most, if not all, community organizations is of considerable importance and value to the community. The purpose of such a psychiatric orientation is to help these agencies to be of greater service in their various community functions. This orientation does not aim to produce psychiatrists through training the personnel of these agencies, but to help them broaden the scope of their own work by an awareness of mental-health implications in their daily duties.

Traveling community-mental-health clinics include approximately the same team as stationary mental-hygiene clinics—that is, a psychiatrist, a psychologist, and a psychiatric social worker. There is, however, one important difference. The traveling clinic is a coöperative enterprise of two distinct agencies—one, the community component, consisting of a specific agency concerned with mental health in the community itself; and the other, the traveling component, supplied by a university medical center, or a state department of mental health, or their equivalents. In further structuring the clinic, one of the community members is generally designated as director, assumes over-all responsibility for the clinic's organization, and coördinates all of its activities.

Generally the psychiatrist and the psychologist are the

[1] *Child Guidance Clinics; A Quarter Century of Development*, by George S. Stevenson. New York: The Commonwealth Fund, 1934.

[2] *Psychiatric Clinics for Children*, by Helen L. Witmer. New York: The Commonwealth Fund, 1940.

traveling members of the clinic, while the social-work services are supplied by the community, since the preparatory work for the clinic and the maintenance of contacts with clients and follow-up service have to be carried on between clinic sessions. This work includes the handling of referred cases, intake interviews, home visits, the scheduling of appointments, and other social-case-work services. Also, the local personnel are better acquainted with their own community resources.

In Colorado, this end of the work has been handled differently in various communities. In some, the clinic has a full-time psychiatric social worker; in others, public-health nurses and social workers of various community agencies are utilized. When a large rural area is being served, the utilization of public-health nurses offers the advantage that these nurses have a great deal of knowledge about their respective districts that it would be impossible for a centrally located worker to obtain. But the lack of a trained psychiatric social worker results in definite handicaps. Intake is not adequately handled, the clinic has no adequate case-work to rely upon, and many difficulties are created for the clinic because of a lack of psychiatric-social-work training among the individuals charged with carrying out the social-work functions of the clinic.

One disadvantage of the use of public-health nurses is that those who profit most from the offered training soon tend to qualify for more advanced positions in other communities, with the result that there is a constant turnover of personnel.

The frequency and length of visits by the traveling members, as well as the size of the traveling group, will depend upon the focus of the clinic service, the community's needs, and the availability of traveling personnel. The clinic service may be diagnostic, therapeutic, or consultative, or any combination of these three. In some instances a clinic may limit its services to certain specific age groups.

It is important that the traveling members of a clinic team have the same orientation toward their work and that they present a consistent viewpoint to the community. In general, the arrangement is one in which the onus of administrative details rests on one individual in the traveling group. The commuting members usually travel together, which in itself

tends to establish an *esprit de corps*. Extensive discussions of cases and projects on the way to and from the clinic help to eliminate conflicts of opinion within the team, thereby increasing its efficiency. This is important, as it allows one member to substitute for or to supplement any other member in the activities of the clinic other than those of treatment. This becomes essential when one of the members is unable to attend a particular clinic session. From this it is obvious that the membership of the traveling team should not be altered unless it is absolutely necessary.

The responsibilities of a traveling community-mental-health clinic are service to the patient, to the agency sponsoring the clinic, and to the community. Service to the patient is concerned with diagnosis and treatment. Service to the agency is primarily consultation and in-service training. And service to the community consists of awakening and stimulating interest in mental-health problems and of helping the community to utilize and develop its own mental-health resources. Of course, these responsibilities cannot be sharply demarcated, but tend to overlap.

The clinic further has the opportunity to demonstrate the harmonious coöperation existing between the various professional disciplines that constitute the clinic team. If the community, by utilizing the services of the clinic, can increase its mental-health resources, it may set an example that will stimulate other communities toward similar efforts.

In addition, the clinic has the responsibility of coöperating with other community, state, and national mental-health organizations. Interchange of information, support of each other's programs, and attempts toward unification of purpose are integral phases of the clinic's efforts. Of course, close contact should be maintained with state hospitals and other mental institutions for a more sound follow-up program after a patient has returned to the community.

The community members of the clinic are responsible for utilizing the resources and peculiar advantages offered by the clinic structure to its fullest extent for client and community benefit. It is they who must interpret the clinic and its services to the community. Efficient organization—including well-thought-out scheduling, usually supervised by the director and adhered to by all members of the clinic team—is

also a community responsibility. Since the demands for services are almost invariably greater than can be met, it becomes the director's job to utilize the available services to the best advantage. Invitations to in-service training sessions come from the director who, after consultation with the clinic team, decides to whom the sessions should be open. He may delegate to other community members of the clinic team the responsibility for scheduling evening talks and special appointments that have been agreed upon in discussions with the traveling members of the clinic.

The traveling group's first responsibility is to offer help to the community in meeting its mental-health needs. The mental-health needs of a community have two principal aspects: one, the diagnosis and, if possible, treatment of patients who constitute a problem to the community; and the other, the encouragement of the maximum growth and development of the potentialities of all of its citizens. In the first category belong problems of feeblemindedness, psychoneurosis, psychosis, delinquency, behavior disorders, learning disabilities, sex offenses, and neurological problems involving central-nervous-system damage; in the second, questions of healthy emotional attitudes, adequate recreational facilities, good educational opportunities, positive labor relations, community harmony, and the use of existing public-welfare activities to promote mental health. The traveling group should feel that it has something to offer and give considerable thought to the needs of the specific community visited in so far as these needs are evident. The traveling members must ever remind themselves that they are not a part of this community, and that their knowledge and understanding of it are very limited. They must respect the community and use discretion when dealing with apparent deficiencies and shortcomings, constantly keeping in mind and honoring the feelings of the community and its limitations in meeting its problems. In addition, the group must repeatedly evaluate its own activities from the point of view of a possible arousal of community resentment and antagonism.

If the above course is not followed, the result can be disastrous to the aims and purposes both of the clinic group and of the community. The community will, of course, judge the traveling members on a personal basis also, and it, there-

fore, behooves them to maintain the strictest decorum both in their professional and in their extra-professional activities.

The clinic as a whole functions primarily in meeting the needs of client and community to the best of its ability, and arriving at the truest possible evaluation of their respective problems. The efforts of the entire clinic team working together thus culminate in an effect that could not be arrived at by any one part of the team working independently and without a coördination of activities between its various members. The aforementioned paper on therapy in a traveling community-mental-health clinic by Coleman and Switzer points this out with further emphasis. Thus the various members of the clinic team function with greater effectiveness because of being unified by the "team concept."

Each individual's functions within the clinic structure may be conveniently discussed under eight subheadings as follows: (1) Therapy; (2) Evaluation and Psychological Testing; (3) Consultation; (4) In-Service Training; (5) Clinic-Community Relationships; (6) Community Education; (7) Community Organizations; and (8) Aid for Community Planning. The therapeutic and psychological-testing functions have been discussed in detail in the papers by Coleman and Switzer and by Thaler, already mentioned, and will, therefore, be omitted from the discussion here, except as they overlap with other functions.

The consultative activities of the community members cover a wide range. They consult with the traveling staff in order better to carry out clinic recommendations and interpret clinic findings to relatives, community agencies, and other individuals concerned with a particular case. The community members of the clinic team also clear up any uncertainties that may arise in individuals who themselves have had consultations with the clinic staff.

From these consultations between the community members and the traveling staff, the latter often learn how best to deal with a particular case at hand by finding out what resources are or are not available in the community. Thus these consultations serve as a bilateral learning process. The community members interest school-teachers, doctors, welfare workers, and law-enforcement officers in the consultative serv-

ices available and encourage visits by them to the clinic for personal discussions with the clinic staff. These consultations are not oriented toward delegating psychiatric functions to these individuals, but toward helping them clarify their problem through explanation and coöperative exploration of ways of dealing with it.

The use to which the consultative services of the clinic are put depends almost entirely on the ability of the community group to awaken interest. Their success in this depends upon the clarity with which they can explain the possible usefulness of the consultative services to those concerned.

The community members, besides attending the in-service training sessions, function in selecting and preparing cases for presentation and in giving information to the traveling members regarding the intricacies and nuances of their own community setting.

In the establishment of clinic-community relationships, the community members play a most significant rôle. They live within the community and have membership in various community orgainzations. Thus they have frequent opportunities to explain and interpret the clinic to the community and in this way are largely responsible for the community's full utilization of the clinic's facilities. To safeguard the relationship of the clinic with the medical society, the inclusion of a local physician in the organization of the clinic is invaluable.

The most obvious way in which the traveling group influences clinic-community relationships is through personal impressions made during its contacts with the community. The frequent talks to community groups offer special opportunity to foster a good relationship with the clinic. This requires good presentation and adequate handling of the anxieties that may be aroused. Considerable flexibility in meeting community demands helps by allaying specific pressures on the community members of the clinic. Special efforts should be made by the traveling group to foster positive relationships with the local physicians. Frequent phone calls and prompt reports are especially useful.

The traveling group's participation in community activities not directly connected with the clinic work indicates its genu-

ine interest in the community. Since the relationship is a bipolar affair, this participation strengthens the reciprocal ties between the traveling members of the clinic and the community. The clinic must continually work toward the maintenance of good relationships with all community groups. It is easy to take such rapport for granted, only to find that it has suddenly vanished.

The local members of the clinic take part in community education by informing the community at large of the types of problem that exist or of instances in which reference to the clinic may be of value. They must keep before the eyes of the community what services a community mental-health clinic can offer and how these may be utilized. The community members must be alert to opportunities to point out the educational facilities offered by the clinic members in the form of talks, discussions, and the like to community groups such as the parent-teacher association, nurses' associations, the bar association, the chamber of commerce, and so on.

In community planning, the local members should be prepared to give constructive help in the psychological structuring and orienting of other community groups and organizations in their respective endeavors. Needless to say, this is more efficacious when requested by the community than when "forced" upon it. The traveling group has the obligation of repeatedly pointing out to the community members of the clinic the uselessness of giving unwanted advice, and of developing with them ways of raising questions that will point up mental-health problems and result in requests for help.

The traveling group's therapeutic and diagnostic functions—discussed in the papers by Coleman and Switzer and by Thaler already referred to— are two of its prime purposes. In fact, these functions are so important that upon their success depends the community's acceptance and support of the clinic. At first the clinic is expected to help in the diagnosis and evaluation of neurological problems and mental deficiency. Only later does the community begin to recognize what the clinic has to offer in cases of emotional maladjustment.

Much of the work done by the traveling members, however, is that of consultation. Through this consultative work, com-

munity relations with the clinic are built up and the clinic point of view is diffused through the community. This diffusion is aided by these consultations about clinical cases far more than by didactic discussions of mental health. Consultations with members of the community are oriented toward helping them become more aware of their own and of community feelings in the case at hand, and to aid them in finding ways and means of dealing with these feelings.

The in-service-training program was conceived to establish a common orientation among all those most closely associated with the clinic. In our case, this included the local public-health director, the public-health nurses, and child and other welfare workers, as well as representatives of other satellite organizations with similar interests. The program includes brief didactic lectures, in layman's terms, on the preparation of patients coming to the clinic, the presentation of such information about psychosexual development as may be of use to the discussions of workers in question, the dynamic and therapeutic aspects of the termination and follow-up of cases, development in the workers of an awareness of the dynamics of their own community, and so on. Emphasis is placed throughout on thinking in terms of feelings.

To conduct a training session with a group of such diverse backgrounds, without loss of poise and the arousal of undue antagonism or anxiety, is often difficult, but it is excellent training for the traveling members. Personnel changes in the traveling group, if frequent, will disrupt the continuity of such a training program.

The traveling team, through its consultations with different community agencies about individual cases, can promote coöperative enterprises among these agencies. As the clinic attempts to marshal many different community mental-health resources about a patient, the community agencies involved get used to thinking in terms of "How can we help this client together?" instead of "How can this other agency help us?" Their work thus becomes more concerned with their client as a whole person.

In community education, the traveling members function primarily in two ways: (1) through consultations as previ-

ously discussed, and (2) through talks and discussions with various community groups and organizations.

Occasionally a traveling team is approached by individuals in the community for aid in setting up community mental-health organizations. As the representative of a medical center, or of a state mental-hygiene department, the traveling team is looked to for assistance and advice in the establishment of such organizations and for information as to their methods and aims. At this point, the traveling members of the clinic must again maintain their awareness of not being a part of this particular community, and for this reason should not take too active a part in such activities, but should help the community clarify its own needs and wishes.

The traveling team has many opportunities, frequently through community members of the clinic, to aid in the dynamic orientation of various community activities other than those that appertain to the clinic itself, and to point out mental-hygiene aspects of any new community enterprise or reformation of existing facilities.

The final aim of the traveling clinic in the larger communities is so to develop local mental-health resources—both through the improvement of those already in existence and through the creation of new ones—that the community will become psychiatrically self-sufficient and the traveling clinic will be free to offer its services elsewhere. Such a community might be said to have "come of age" psychiatrically.

A prerequisite to the achievement of this goal would be the procurement by the community of a full-time psychiatrist, interested in community-mental-health work. It is hoped that the increased sensitivity of the community to mental-health problems and the growth in the demand for services created by the traveling clinic will hasten that day.

For the small community incapable of supporting its own psychiatrist, the traveling clinic's aim is to reach the point where it can adequately meet the community's demand for services.

Last, but not least, the traveling community clinics serve one other important purpose in Colorado—that of training the traveling personnel in community psychiatry. These clinics place both senior psychiatric residents and graduate

psychologists in a situation in which they have no one in their immediate environment to call on for help. They must learn to deal with group and community dynamics and feelings for an extended period of time. This forces the traveling group to reëxamine and reorient its own psychiatric and psychological thinking in terms of community as well as individual forces.

The traveling clinics also offer the senior psychiatric resident his first experience with administrative psychiatry, which is a science in its own right, apart from patient-oriented therapy.

THE CHANGING SCOPE OF SOCIAL WORK IN THE NEUROSYPHILIS CLINIC

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WITHIN the past few years many therapies that have been widely accepted for the treatment of different categories of mental illness have greatly affected the scope of the social worker's activity. The literature of recent years [1] has repeatedly called attention to her changing function, molded as it is by the search of the doctors for newer and easier methods of helping the mentally ill. The general adoption of insulin and electro-shock,[2] for example, gave her greater latitude for the reassurance and support both of patients and of families. Fortified by the hope that a new method of treatment always instills, the worker could approach the task of post-discharge planning with greater confidence. Again, the extension of electro-shock treatments to outpatients reaffirmed and strengthened the worker's rôle of environmental diagnostician, for it became her province to evaluate those home conditions and attitudes that would be helpful or detrimental to the mentally ill patient who remains at home while undergoing treatment.

As doctors shifted from their early view of the worker as a "history taker" and receptionist, to one that regarded her as a member of the therapeutic team, they found more uses for her mothering contributions.[3] They found that they could utilize these for generating warmth in the recovering patient and for helping him form relationships in the community. Finally, doctors, with greater frequency, began to avail themselves of the worker's wealth of experience to aid them in research projects.

[1] See "Psychiatric Social Work Possibilities in a Mental Hospital," by Elizabeth B. Beck. *Journal of Psychiatric Social Work*, Vol. 18, pp. 173–82, Spring, 1949.

[2] See "Recent Developments in Treatment in Mental Hospitals," by Ethel B. Bellsmith. *Journal of Psychiatric Social Work*, Vol 18, pp. 3–10, Summer, 1948.

[3] See "The Psychiatric Social Worker's Concern with Electro-Shock," by Paul Federn. *The News Letter*, Vol. 15, pp. 15–17, Autumn, 1945.

These changes in the social worker's rôle have been sketched because another new remedy, penicillin, has similarly brought about radical changes in an old field of social-work endeavor. The general adoption of penicillin as the chief treatment for neurosyphilis has completely revolutionized the social worker's former routines. This paper is a presentation of the changes brought about on the neurosyphilis service and the social worker's activity there. While it is wholly descriptive of the neurosyphilis clinic at the Boston Psychopathic Hospital, the literature emanating from other similar services in hospitals in other parts of the country suggests that the experiences here are representative, in general, of experiences elsewhere.

The Neurosyphilis Clinic at Boston Psychopathic Hospital has served the state of Massachusetts, and particularly the Greater Boston area, since 1922 with two major services—the inpatient wards and the outpatient clinic. Cases of all types of neurosyphilis are cared for as inpatients, but the majority are patients with mental symptoms. Malaria and fever-cabinet treatments were instituted about 1924. For both types of fever therapy, a staff of experienced personnel is required for the pre-treatment evaluation as well as for the administration of therapy.

The outpatient clinic is held on two mornings each week for the purpose of diagnosing cases sent to it by doctors and venereal-disease clinics throughout the state and for the follow-up observation of discharged patients. Since 1944 a great part of such patients have been treated with penicillin and form a special research group for testing the efficacy of penicillin as a cure for neurosyphilis. For the first two years after their discharge, patients are requested to return to the clinic every three months for spinal punctures and clinical studies. Three and four years after receiving penicillin, they are seen twice during the year. In the fifth year following treatment and thereafter, patients may come on an annual basis.

Prior to the general use of penicillin in 1944, patients were required to come to the clinic at least weekly for many months. The older therapies called for weekly or bi-weekly injections continuously for several years. Thus the clinic served an average of 60 patients a morning, or about 120 per week. Two

doctors and two nurses were required to be in attendance, taking bloods, performing spinal punctures, and giving treatment injections. The social worker on duty acted as receptionist, routed patients to the proper offices, recorded their visits, and otherwise acted as the friendly intermediary between doctor and patient. Where hardship existed, she facilitated getting to the clinic, and urged the patients not to drop out of treatment.

The adoption by the hospital of penicillin treatment brought immediate changes in this order. For about two years there was an increase in the number of hospitalized patients because resistant cases were admitted from the outpatient department for inpatient treatment with the new drug. New patients, inadequately treated or never before treated, were sent to the hospital from all corners of the state, since until 1946 the Boston Psychopathic Hospital was the only state hospital where penicillin was available.

With penicillin treatment, the duration of hospitalization is much shorter and the patient turnover is greater. Those requiring fever in addition to penicillin are often kept for several months, depending upon their individual needs and on the speed with which their mental symptoms subside.

Gradually, as penicillin became more generally available, the ward intake began to drop. General hospitals which had formerly not been equipped to treat neurosyphilis began to treat relatively asymptomatic patients because penicillin is easily administered and requires little personnel. As a result, patients without mental symptoms or without severe tabetic signs have come to Boston Psychopathic Hospital less frequently. From the earlier average of 25 patients per month, the ward population of neurosyphilis patients has slipped to its present monthly average of two. Malarial and fever-cabinet therapy have been abandoned. Some patients who show severe alterations in mood or overactivity are being given a series of electro-shocks in addition to anti-syphilitic treatment. Rarely insulin treatment may be used also.

The drop in outpatient-clinic activity has been similarly marked. The abandonment of chemotherapy altered the function of the clinic. Where formerly its chief focus was on long treatment, only the two functions of diagnosis and follow-up study remain to-day. From an average of 120 patients per

week, the number has been reduced to six. Fever cabinet and penicillin may occasionally be given on an outpatient basis, but they are usually administered by the regular hospital nursing service since the neurosyphilis personnel has been correspondingly reduced.

In the days when both hospital and clinic intake were high, the social worker was hard-pressed to meet all the demands for her services. Her work had four major functions: (1) as an aid to the doctor in bringing patients and infected relatives to treatment; (2) as an adjustor of attendant social problems; (3) as an interpreter of the clinic to the community; and (4) as an assistant in gathering material for research. But her greatest efforts were of necessity in the realm of bringing patients to treatment. Because treatment was so prolonged, many patients dropped out as soon as they felt better. It then fell to the worker to get into contact with them and reiterate the importance of continuous injections. Familial examinations were time-consuming as well. Then, as to-day, patients were reluctant to disclose to their families the nature of their illness, and it would tax the ingenuity of the worker to bring about examinations of possible contacts. Help with social problems was largely in the realm of supplying tangibles. With a large population to care for, the worker concentrated on the area of greatest need. She found little time for individualization of the patient or for helping him with the variety of emotional problems resulting from his illness.

Greatly diminished patient numbers have altered and strengthened the worker's rôle. Released from much of her former rote work, she now is able to devote more time to each patient or to his family. The encouraging results of treatment by penicillin permit her to reassure more readily than hitherto. These aid her, too, in her purpose of involving relatives, especially rejecting relatives, in the treatment plan.

In the follow-up clinic, she is able to talk at length to the patient and to whichever family members accompany him to the clinic. There is a twofold purpose to these conversations. The clinic is anxious to know the vocational and social adjustment of its discharged patients for research purposes and is desirous at the same time of offering case-work services to facilitate these adjustments. As patients begin to see in the

worker a person to whom they can bring their problems, they bring a greater variety of them to her. Many requests are still for services, but an increasing number have been appeals for help with a variety of problems, all rooted in the stigma of the syphilitic infection.

For example, Mrs. P., the wife of a paretic patient, was so outspoken about the cause of her husband's illness that she undermined the confidence of both her adolescent children. The daughter, a student in high school, developed hysterical symptoms. The son began to fail in school. Brought to the worker's attention, the daughter was referred to a psychiatrist in the psychiatric clinic, while the mother was seen intensively for a year by the worker. Ultimately the mother relaxed her attitude and permitted the children greater freedom of development.

In another case a marital situation was smoothed out after the worker demonstrated to the wife of a patient how her own repeated illnesses were calculated to punish her husband for having become infected. She ceased making the rounds of hospitals and clinics, and settled down to helping him economically by taking a part-time job.

Many cases, though suitable for reference to other agencies, are handled by the worker because patients and their families refuse to be referred elsewhere. They prefer to limit the knowledge of their infection to one hospital. Once having achieved acceptance and understanding without loss of self-esteem, they seem not to wish to tempt rejection in other quarters.

Yet another important result of penicillin therapy is that it rehabilitates a greater number of patients who have been ill and untreated for a fairly long period of time. In a recent study,[1] it was found that of a group of patients who had been ill an average of two years before treatment, 36 per cent were returned to gainful occupation. Most of these actually had some brain damage which manifested itself by impaired memory and faulty reality testing. As individuals they give the impression of being somewhat childlike, dependent, and

[1] "Clinical Follow-up Studies on 130 Cases of Long-standing Paretic Neurosyphilis Treated with Penicillin," by Augustus S. Rose and Lida R. Carmen. *American Journal of Syphilis, Gonorrhea, and Venereal Diseases*, Vol. 35, pp. 278–83, May, 1951.

often impulsive. In a general way their pictures approximate those of ambulatory schizophrenic patients. Work with them is similar to that of work with other schizophrenic patients, in that it is largely supportive and related to reality functioning. Although they are seen by the doctor for spinal-fluid examinations and clinical evaluations, the main rehabilitative responsibility for them seems to rest with the social worker.[1]

Before discharge from the hospital and even afterward, it is the worker's task to interpret to the family the residuals of the patient's illness and engage them in the therapeutic process. Patients may show loss of memory, or childishness, or diminished drive, for which the family may be unprepared. Because of the basic infection, families are prone to reject the returning members, even though the hospital considers them fit to return to the community. A punitive wife will sometimes seize upon the smallest evidence of mental aberration to return her husband to the hospital rather than expose him to the scrutiny of their friends. A family priding itself upon its respectability may look with alarm on the black sheep who is sent back to them for rehabilitation.

Many paretic patients, especially those whose illness has been diagnosed and treated promptly, are returned to their jobs. Many go back to their former work, but some, because of mental slowing up, must take jobs on which they do not need to work as intensively as before their illness. In both instances, it is the province of the worker to interpret the patient's illness to the employers in a manner that will assure the patient that he will have a job to return to. Where the patient is forced into a job on a lower and less remunerative level, the worker must focus her efforts on the family, to be sure that they fully understand his reduced competence in spite of an outer appearance of excellent health. A good percentage of patients never become gainfully employed after their discharge. Yet they can be put to small uses in the home, doing simple repairs, chores, gardening, or housework. They can be made happy if the family will coöperate.

Sometimes the focus of the worker is on the patient himself. She can be available to him for reassurance and consultation when he finds himself at an impasse either in his social rela-

[1] See "Social Case Work as Therapy," by Myron John Rockmore. *Journal of Psychiatric Social Work*, Vol. 18, pp. 182–89, Spring, 1949.

tionships or in his efforts to obtain satisfactory employment. Paranoid patients sometimes drop in to see the worker because they think some one in the community is spreading the knowledge of their infection. They need to be assured of the clinic's reliability in the matter of keeping confidences. Some timely assurance and restatement of realities by the worker may keep them from moving to another address or changing jobs, since their paranoid thinking has it that people know all about them.

Another area of necessary skill on the part of the worker is that of dealing with other community agencies. The repeated and insistent demands of many former patients may soon exhaust their welcome in other agencies. The worker must keep in touch with local welfare offices, rehabilitation and recreation centers, coöperating clinics, and veterans' services, and their good offices must be enlisted by continued and effective interpretation of the patient's limitations.

It is still uncertain whether penicillin is the long-sought-for cure for syphilis or whether it extends life only to have the patients peter out more gradually of their infection.[1] Doctors are still cautious about making definitive claims about the efficacy of this wonder drug. Only after more years of careful follow-up and study can they hope to arrive at valid data.

It is in the collection and compilation of this data that the social worker is again of help to the doctor. In her traditional rôle of follow-up agent, she can use her knowledge of human needs, interpersonal adjustments, and environmental pressures to accumulate social data with which to complement the case-work; she can establish good rapport with the patients to the end that they will continue their clinic attendance. Through winning the confidence of the patients and sharing with them the reasons for their repeated clinic visits, she can best serve the purposes of therapy, case-work, and research.

[1] See "Is Venereal Disease No Longer a Problem?" by E. Gurney Clark. *American Journal of Syphilis, Gonorrhea, and Venereal Diseases,* Vol. 34, pp. 401–04, September, 1950.

THE DISTURBANCE OF THE MOTHER-CHILD RELATIONSHIP BY UNSUCCESSFUL ATTEMPTS AT ABORTION *

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CHIEF among the many interrelating factors that mold a child's personality is the type of handling he experiences from his mother, and this is largely dependent on her emotional attitude toward him. A healthy relationship is characterized by the mother's reacting primarily on the basis of her perception of the child's real needs. Experience in child-guidance clinics has shown that a disturbed relationship of a kind likely to pervert the child's development is based on the mother's using the child as an aid in solving her own emotional problems. Such a mother deals with her child mainly to suit her own needs, and she manipulates him with little regard for his individual rights.

Realization of the potential danger of such disturbances of the mother-child relationship has stimulated an attempt to discover and relieve them before signs of damage appear in the child. This approach is based on the belief that in many cases it will be easier to modify the mother's harmful attitude than to cure the complex neurosis in the child to which it may give rise.

The Lasker Mental Hygiene and Child Guidance Center of Hadassah in Jerusalem has been carrying on research in this field during the past three years.[1] A study is being undertaken of mothers of young children in well-baby clinics of the Jerusalem Public Health Service, and criteria are being

* A revision of an article published in the *Courrier* of the International Children's Centre, Vol. 2, pp. 193–201, 1952.

[1] See "Mental-Hygiene Work With Expectant Mothers—A Group Psychotherapeutic Approach" (MENTAL HYGIENE, Vol. 35, pp. 41–50, January, 1951), and "A Public-Health Approach to Child Psychiatry" (MENTAL HYGIENE, Vol. 35, pp. 235–49, April, 1951), both by Gerald Caplan.

worked out for identifying mothers whose relationships to their children are disturbed. Techniques have been developed for bringing these into a treatment relationship with a psychiatric social worker, who uses a focused type of case-work interviewing method. This aims at a radical treatment of the disorder in the relationship, without involving the giving of psychotherapy for whatever intrapsychic conflicts the mother herself may reveal.

In the course of this work much is being learned about different types of disordered mother-child relationship, and the original causes of these disorders are being uncovered. Many of the etiological factors are rooted in the complexities of the mother's psychological structure and have their origin in her own childhood. It has, however, been found that some of the factors that produce these unhealthy relationships originate in traumatic situations in the mother's recent experience.

This discovery arouses the hope that by detecting such traumatic situations and dealing with them while they are acute, it may be possible to prevent them from harming the mother-child relationship. Moreover, since at the time they occur or soon afterwards no deep change may yet have taken place in the mind of the mother, it is possible that the problem can be adequately dealt with by nurses, pediatricians, and obstetricians, and so not need the special skills of psychologically trained workers.

The present paper is an attempt to focus attention on one of these traumatic situations, and to bring the matter to the attention of a wide circle of public-health workers, in order to enlist their help in dealing with it from a mental-hygiene point of view.

Analysis of the records of 180 cases of disordered mother-child relationships, encountered during the first two years at the Lasker Center, draws attention to the significance of a history of an unsuccessful attempt by the mother to terminate her pregnancy. Thirteen such cases have been dealt with. In addition, three cases were seen in which, though no physical attempt at abortion was made, the mother made a serious plan to abort which was frustrated before she did anything to herself. In three other cases the disturbed relationship was initiated by the successful abortion of a subsequent preg-

nancy, but these will not be considered in the present context.

All cases were referred by the public-health workers because they suspected a disorder of mother-child relationship on the basis of their observation of the behavior of mother and child during the routine clinic visit.

In the sixteen cases in which there had been a failed attempt or a frustrated plan of abortion the chief criteria on which reference was based centered around problems in the child. These represented a typical selection of the mild disorders of early childhood usually encountered in well-baby clinics—feeding disturbances, aggressive behavior, overdependence, phobic fears, bed-wetting, and so on.

The following case illustrates some of the typical findings, and can serve as a basis for a discussion of the problem.

David B., aged four years, one month, was referred by the pediatrician of one of the well-baby clinics after a routine check up, prior to his file's being closed because he had reached the upper age limit of the clinic. His mother had told the doctor that the kindergarten teacher had drawn her attention to his asocial behavior, and she herself was worried because he was so subdued, passive, and unaggressive. She said that although she had not brought David to the well-baby clinic for about a year, she was taking him regularly to private doctors and other clinics because he was small and had severe feeding disturbances. The latter had improved a little lately, but she still had to spend about three hours with him at most mealtimes.

Physical examination revealed a thin, undersized child, but no organic disorder. Examination at the Lasker Center showed a serious, lethargic, and sometimes sleepy child who made poor emotional contact with the examiner and who behaved generally in a correct, overcompliant, and unaggressive manner. Tests showed him to be of above average intelligence and his play evidenced a vivid phantasy life, the expression of which was, however, limited by a compulsive tidiness and an obsessional preoccupation with symmetry and order. A tentative diagnosis of early personality disorder with obsessional trends and with marked inhibition of aggression was confirmed during subsequent contacts.

Both parents were seen, and they said that they had been married close on five years. They had one other son, Yaacov,

aged two, an outgoing, active, happy child, who had never given any trouble. From their statements it appeared that their relationship with this younger child was excellent. They had been rather strict over habit training, but without ill effect. Their attitude toward him was quite relaxed, contrasting markedly with their intense worry and preoccupation over David.

The parents were Iraqui Jews. The father, aged thirty-five, had come to Jerusalem twenty years before. He was very ambitious, had worked his way through evening classes, and had eventually become an engineer, but was still not earning more than a modest wage. He was the son of a rabbi and kept a religious home. He was obviously an intelligent man, but rigid and mildly obsessional and very worried about the child. He spent a lot of time with David, reading to him from books like *The Young Engineer,* and also helping him in "constructive play."

The mother, aged twenty-nine, had lived fifteen years in Jerusalem. Her childhood had been hard, and she had gone out to work at the age of ten. She was a sociable, gentle, warm woman who appeared happily married and who, though rather shy, had a number of close friends to whom she showed a healthy attachment. The one sphere of her life that appeared disturbed was her relationship with David. In regard to him she was extremely anxious, and it was clear from her story that her handling of him was changeable and ineffectual. She was very overprotective, and worried excessively about all the details of his health.

It was felt that David needed treatment by play therapy, and since the relationships to him of father and mother seemed disordered, both parents were accepted for case-work treatment. Apart from possible constitutional elements, the chief pathogenic factor appeared to be the disorder in the relationship between mother and child, and it seemed likely that some specific cause would be found for this, because her disturbed attitude to David was in such marked contrast to her good relationships with her other child, her husband, and her friends.

No further details will be given of the treatment of father and child, nor of the case as a whole; but an attempt will be made to summarize information obtained during regular

weekly contacts with Mrs. B., which permits a formulation of the nature and origins of her disturbed relationship with David.

Throughout the treatment, Mrs. B. spoke with great emotion about the child's feeding difficulties, which had begun as soon as he was born. When she had first put him to the breast, she had been very much upset to find that he was lazy and would not suck. He often vomited, and she has had him under doctor's care since birth. She has tried force, persuasion, and sometimes starvation, but nothing has helped. His feeding difficulties have continued ever since. The injections, pills, and electrical treatment prescribed by the doctors produced no improvement.

Nowadays he sits for about three hours at each mealtime, keeping the food in his mouth and dreaming. She cannot bear to force him as the teacher does in the kindergarten. "He must hate the teacher, stuffing food into him like that. If I pushed food into his mouth, he would hate me, too." But every now and again she loses patience and beats him; and lately she puts him to bed in the dark without toys till the next mealtime to persuade him to eat. After such punishments, she is obsessed for days by the fear that he won't love her.

Mrs. B. mentioned in the first treatment interview that her first pregnancy, which occurred immediately after marriage, was unplanned and unwelcome because both she and her husband were working hard and trying to save money for a home. Also, conditions in Jerusalem were unsettled due to Arab-Jewish fighting. She vomited a lot and had a bad time. Her second pregnancy was also unwanted and she was equally ill, but both births were normal and easy.

During the third and fourth sessions, it became obvious that she was withholding some information from the case-worker. In the fifth session, after some encouragement, she blurted out with a considerable show of guilt that she had taken some pills in the second month of her first pregnancy in order to terminate it. When she found that the drugs did not work, she took mustard baths and ran up and down stairs. Later she went to a doctor, who, however, refused to perform an abortion. All these things were done secretly, in great fear that her husband or family would find out. The family is religious, and abortion is regarded as a grave sin. Her vomiting

increased after the attempts at abortion, and during the rest of the pregnancy she was terrified that she had damaged herself and the child within her. Because of this painful experience, she had made no attempt to interfere with the course of the second pregnancy, although it was equally unwanted.

This story had been a great burden to her, and she felt considerably relieved when she was able for the first time to share it with some one else. During subsequent sessions, she was able to talk more freely about the child's problems and her reaction to them, and in this she was greatly encouraged by the sympathetic and non-judging way in which her confessions were received.

She described with some guilt her handling of habit training, which she had begun at nine months. At that time the child used to wet several times an hour, and she would hit and scold him because she felt that he did it on purpose to annoy her. He had become dry at night when a year old, and dry in the day at one and a half.

At ten months she had left him alone in the house for some hours and on her return found that he had soiled and smeared himself, had opened a cupboard and broken some crockery. She beat him severely and he never soiled himself again. It was really the broken crockery that had upset her so much.

Until he was a year old, he continued to be "overactive and unruly," and she beat and scolded him a great deal. His unruliness then subsided and he became very quiet and serious, growing quite rapidly into "a little old man." She felt that his increasing shyness was inherited from her, because she has always been rather shy and has never liked fighting or quarrels.

She said she had always been afraid that people would think she neglected the child, because he looked so small and weak. Yet he was "the center of her life," and she was always taking him to doctors for treatment. She had feared that he had heart trouble or a blood disease, but no abnormality was ever found. The doctor always reassured her, but she could never rest, and imagined all kinds of new illnesses. During the early stage of his treatment at the Lasker Center, she was taking him practically every day to different doctors and clinics.

Mrs. B. had great difficulty in accepting the permissive attitude of the play therapist at the center toward the child,

and she became quite upset as he became more aggressive during the course of his treatment. Her great fear was that he might break things at home or hurt other children. On such occasions she became very angry with him, and was afterwards ashamed and guilty at her cruelty to the child, and afraid that she had harmed him. On one occasion he refused to wash himself. She flew into a rage, tore up some pictures he was collecting, and threatened to scrub him with a rough brush. On another occasion she sent him off to the kindergarten without saying good-bye to him because he would not eat his breakfast.

In one interview she said, "I treat him like a holy person over whom one has to watch and guard. I treat him like an apple in cotton wool—but even such an apple gets spoilt and rots—and sometimes if one watches an apple too much, one is afraid it will fade away. At times I curse the day of his birth." She said she was afraid of his getting dirty for fear he might get sores on his skin, and yet she knew that he should not be so clean, delicate, and girlish. He had night fears and dreams of being killed, but she refused to leave the bedroom door open or to burn a night light, for fear that he might get bad habits and become soft and weak. "At times I think he is so weak and does not grow because of the pills I took in pregnancy."

The attempted abortion was mentioned over and over again during the interviews. Mrs. B. often talked about her fear that during pregnancy she had damaged the fetus, and how tremendously relieved she had been after birth to discover that he was not a monster. But when she put him to the breast and he refused to suck, she felt that her fears were confirmed, and that the pills had really injured him. She had always felt that by his negativistic behavior at mealtimes he was paying her back in some way for the harm she had done him. Whenever he was off color, she felt very guilty and frightened, and occasionally remembered the abortion, although she had done her best to forget it and persuade herself that nothing could have happened. She had often wanted to ask the doctors about it, but had been too frightened.

As she continued to discuss the abortion with the caseworker, her guilt feelings gradually subsided, and little by little she began to feel less frightened about the child; and

she began to leave him more freedom for independent expression.

Of the fifteen other cases of planned or attempted abortion, the records of twelve are full enough to allow of comparison with the above case history. In six of these the incident of the attempted abortion appears as the central factor in the causation of the disorder of the mother-child relationship, as in the case of Mrs. B.

It seems very likely that had Mrs. B. not attempted to abort the child, her relationship to him might have been like that with her other child, who had also been unwanted. Certainly her feelings of guilt and fear in regard to the abortion can be clearly traced as causative factors, beginning in early pregnancy and linking up with the various details of her relationship to the child up to the time she came for treatment. In her reactions to David's behavior, she appears primarily motivated by his stimulation of her fears or her guilt feelings; and it is her own needs that govern her actions rather than any attempt to satisfy his. Thus, because of her guilt in regard to the abortion, she expected the child to be a punishment, and though she was relieved when she found she had not given birth to a monster, she immediately fastened on his lethargy at the breast. This was the beginning of the feeding difficulty that became the bane of her life. Very clearly her own handling of the difficulty served only to perpetuate it; and during treatment she came to see how she was using it to punish herself.

Apart from manipulating the child to punish herself, she was using him also to symbolize her own badness. She was hypersensitive to any signs of aggressiveness or destructiveness in the child, and she behaved as if these were externalizations of the evil feelings that had caused her to attempt to destroy him *in utero*. The cruelty with which she dealt with every sign of aggression in him contrasted with the gentleness and warmth that characterized her other interpersonal relationships. This can be understood by realizing that in effect David was not to her a separate individual, but part of herself, and in tormenting him she was trying to stamp out her own badness. A similar identification of the child with the "bad self," leading to cruel and sadistic treatment, was observed in four of the other six cases in which abortion

was the central factor in causing the disordered mother-child relationship.

Another notable feature of Mrs. B.'s relationship to David is her intense fear about his health, which is connected with her feeling that she had injured him by the attempts at abortion. This fear was present even before his birth, and continued unabated till she came to the Lasker Center. Her hypochondriacal worrying about his health was impervious to all reassurance, and she went from doctor to doctor almost trying to persuade them to agree that the child was ill. This fear led to an overprotectiveness that was strangling the child's development. She dimly recognized this during treatment by her graphic description of his resemblance to "an apple in cotton wool," which may rot and fade away. The other four cases in which abortion had been attempted were also characterized by such fear and overprotectivenss, but not the two cases in which there had been a plan to abort, but no actual attempt made.

The potency of the attempted abortion in disturbing Mrs. B.'s relations with David is associated with her emotional reaction to this act. She had kept it a complete secret until she was helped to confess during the treatment; and it was obviously associated in her mind with overpowering feelings of guilt and fear. Apart from individual factors in her personality, which led her to react so strongly, the attitude of her family and subculture toward abortion must be taken into account. Among her relatives, abortion is regarded as a terrible sin almost akin to murder, and this certainly increased her guilt and the necessity to keep her secret.

It is of interest to compare these factors in the other cases of the series. In the six cases in which the abortion was the significant factor in disturbing the mother-child relationship, the mother talked about her act with difficulty and with strong expressions of guilt, shame, and fear. In all these cases the subcultural group was strongly opposed to abortion, and in all of them the act was kept a complete secret, or had been confessed only to one or two close relatives. On the other hand, in the six cases in which the abortion was judged to be a minor or insignificant factor, the mothers discussed their act easily and in a matter-of-fact way. In none of them had there been any attempt at secrecy. All

these mothers belonging to subcultural groups among whom there is little or no opposition to abortion.

In this connection it may be mentioned that the sixteen abortion cases appeared to be a random sample of the subcultural range of the Jewish population of Jerusalem, including Jews from France, Yemen, Iraq, Persia, the United States, Russia, Germany, Morocco, and Kurdistan, so that a large range of subcultural attitudes was possible.

One outstanding aspect of the case of David is the fact that although his mother's relationship to him was so disturbed and pathogenic, she herself has a very normal, and even nice, gentle personality. Three of the other six cases in which abortion was a central factor also showed mothers with stable personalities and good general interpersonal relations. Five of the six mothers whose planned or attempted abortion was not felt to be directly responsible for the disturbed relationship to their child were, on the other hand, judged to have marked disorders of personality structure.

The specificity of the disorder of Mrs. B.'s relationship to David was marked. Her relations with her second child, who was equally unwanted, were excellent and so was her relationship with other people. Five of the six mothers whose relationships had been disturbed by abortion had other children, and in every case their records show good relations except with the child they attempted to abort.

The reasons given by Mrs. B. for her attempt at abortion were typical of the other cases in which the attempt proved pathogenic to the mother-child relationship. In all except one, the pregnancy was unwanted for economic reasons. On the other hand, out of the six cases in which abortion itself was not the cause of the disturbed mother-child relationship, five mothers gave marital disharmony as their reason for not wanting a child; and analysis showed that in four of them, both the abortion itself and the subsequent disorder of relationship were based on the mother's identifying the child with her rejected husband.

For the purposes of this paper, it may be as well now to summarize some impressions derived from an analysis of the case of David B. and the six other cases in which an unsuccessful attempt at or plan of abortion was the direct cause of a disturbed mother-child relationship.

The attempted abortion, it appears, aroused strong feelings of guilt, shame, and fear in the expectant mother, partly as a reaction to a cultural taboo, and her guilty secret later disturbed her relationship to her child. This disturbance was characterized by inability to react to him as a separate individual, with his own justifiable needs. She behaved as if he were the punishment she expected for her crime; and also she identified him with her own "bad self," so that she dealt in a cruel way with his every expression of aggressiveness. Her fear of the consequences of her act led to an irrational anxiety in regard to the child's health, which in turn produced a smothering overprotectiveness. Most of these mothers were normal, stable people with good relationships to their other children, and they had been led to attempt abortion for economic reasons.

It must be emphasized that the number and selection of cases in the present series does not justify any definite conclusions of a statistical nature as to the ill effects of failed attempts at abortion. Only if a large random sample of unsuccessful abortions is followed up will it be possible to ascertain how important this factor is in disturbing mother-child relations, and what accessory factors determine its harmfulness.

It would appear, nevertheless, that these findings imply that an unsuccessful attempt at abortion, especially by a mother living in a culture strongly opposed to this practice, is likely in certain cases to lead to a disturbed mother-child relationship of a type harmful to the child's personality development. It is, therefore, suggested that public-health workers, while awaiting further exploration of this question, may profitably take mental-hygiene action in all cases of failed abortion that they meet.

The object of such first-aid measures is to reduce the mother's excessive guilt and anxiety as soon after the attempted abortion as possible. It is likely that in many cases this will not be too difficult during pregnancy or early in the child's life, before the mother's painful emotions have involved her in a vicious circle with the child's reactions to her disturbed handling.

Most public-health workers are familiar with various techniques for reducing anxiety. Some may prefer to adopt an

authoritative or parental attitude and confidently dismiss the fear: "There is no need to fear. I say it is quite all right." Others may use a technique more suited to reassuring an adult; the mother is made to feel less dependent because her critical faculties, instead of being by-passed, are actively involved. She is encouraged to talk freely about her fears; and the worker recognizes them and discusses them in a way which implies that they are groundless. Rational explanations, which confront the mother with objective reality, so that she can see for herself the irrational nature of her anxieties, may also be used.

Unfortunately such measures of reassurance will not succeed in most cases of failed abortion, as was clearly seen in the example of Mrs. B. She went from doctor to doctor, and remained just as worried after each one had reassured her and had enlisted the aid of suggestive devices like injections and electrical treatment. The reason for this lack of success is that the fears are secondary to a feeling of guilt, and unless this is first dealt with, no amount of reassurance, however skillful, will have more than a temporary effect.

The relief of a mother's conscious feelings of guilt is not a complicated task, but it demands a special attitude on the part of the public-health worker. The latter must be prepared to accept the mother in a non-judging way as a fellow human being in difficulty. He must be objective and at the same time sympathetically interested. This attitude toward a mother who has attempted to terminate her pregnancy may be rather difficult when the worker is closely identified with a culture that strongly condemns abortion. And it is likely that it is in such cultures that the failed abortion is most harmful. If the worker does not feel able to separate his therapeutic rôle from his personal attitude to abortion as a sin, it will be better for him not to attempt to reduce the mother's guilt, because he may unwittingly increase it by implying his real condemnation of her.

There is no doubt that the best way of preventing the harmfult effects of unsuccessful abortions is to educate mothers not to interfere with the natural course of pregnancy. Moreover, it cannot be the function of the public-health worker to deal with the normal workings of a mother's conscience when she feels that she has done wrong by acting contrary

to her religion and moral values. However, recognition of the fact that excessive and secret guilt may not only be self-punishment for the mother, but may lead to pathological anxiety and adverse attitudes toward her child suggests that the worker does have the task of helping the mother to recognize this guilt, so that she can deal with it in a constructive way that will help and not hinder the child's development.

The worker who has faced this problem in himself and is confident about defining his rôle as a therapist can undertake the task of helping the mother come to terms with her guilt. He should assist her to discuss with him what she has done, and her guilty feelings about it, so that she can work out a healthy attitude toward her act. Such discussion should preferably begin after the mother has been allowed to get to know the worker, and to recognize that in him she is dealing with a person of understanding, who is prepared to allow her time to talk and is willing to listen without judging her. Shortage of time is the bugbear of most public-health workers, but sometimes the allocation of a few fifteen-to-twenty-minute sessions may mean a clear saving in the prevention of loss of clinical time over many years to come.

The way in which the mother is invited to discuss the abortion is of some importance. Suspicion will usually have been aroused by her answers to routine questions during history-taking, or by her anxiety during the physical examination. She should not be cross-examined, because she will then feel accused. Instead, the subject may be tactfully broached along the lines of "I understand that because the pregnancy was so inconvenient, you tried to terminate it. Most people would feel rather wretched about that and might worry a lot. Perhaps you would like to discuss how you feel." No attempt should be made by the worker to slur over the act of abortion; on the contrary, it should be faced squarely and objectively. But there is no need to press the mother for more details than she is prepared at the time to volunteer.

Some mothers may show no overt signs of guilt while discussing what they have done. This may be because they are so afraid of what the worker may feel about them. In such cases it often helps if expression of guilt is stimulated by some such formulation as "Mothers often feel bad after they

have done this. Most of them start worrying that they may have injured the child." Such formulations make it easier for the mother to talk because the worker has put the idea into words and broken the ice; he has shown by his tone of voice that he is sympathetic and non-judging; and he has indicated that many other mothers have done likewise. One of the worst feelings produced by a guilty secret is that one is quite isolated in one's wickedness; to hear that other people have done the same thing brings tremendous relief.

Once the mother has been helped to discuss the abortion, she should be given at least one or two further appointments in order to help her realize that the worker remains interested and on good terms with her even though he has "learned the worst." In the second or third interview, when it is felt that the pressure of her guilt has been relieved, the worker can take up the question of her fears about the harm she may have done the child, and reassure her specifically on this point.

These few technical suggestions indicate the general line of approach to the problem, and by meditating on its social and moral implications, the individual worker can develop methods in keeping with his own personality. It is suggested that these measures, if applied during pregnancy or in the first months of the child's life, may well prevent the succession of events described in this paper. This may be a significant contribution to promoting a free relationship between mother and child which is a prerequisite for mental health, and it may save the pediatrician and the psychiatrist much work in the future.

BABIES ARE TAUGHT TO CRY: A HYPOTHESIS

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INTIMATE observation of the writer's own children, supplemented by more casual observation of many others, suggests the hypothesis that babies cry largely because they are taught to do so. While crying is a natural, primitive reaction in situations of distress—an *unconditioned* response, in the vernacular of the behavioristic psychologist—this mode of expression or communication is later employed quite generally by the infant because his other signals are not heeded. In technical jargon, crying as an unconditioned response becomes reinforced by learning. The child then proceeds to cry in order to make his wants known in situations that are not in themselves painful or sufficiently distressful to elicit crying as an unconditioned reaction.

The way in which the parent or other attending adult accomplishes the result here postulated is not hard to understand. For centuries it has been the common belief that babies cry naturally. The *expectation of the parent* that the baby will cry and that one can do nothing about this unpleasant practice actually leads *the baby to expect* that he must cry in order to be understood. It is on this basis of mutual expectation that the child finally learns to cry; unwittingly the parent has taught him to do so.

The learning process is as follows: In situations of real distress at the beginning of life, the infant cries or screams as an unconditioned response to pain. Ordinarily he then experiences relief, since the attending adult hurries to his aid. In other situations requiring the attention of an adult, the child may emit various *other* unconditioned responses closely related to the need in question. For example, he may smack his lips or protrude his tongue as a signal that food is desired. If, however, the parent fails to respond to this type of signal, the baby soon finds himself in a situation of distress in which crying becomes the natural mode of expression. He yelps and

the parent comes. In this way the child learns to substitute for the more direct smacking of the lips—or other comparable response—the response of crying.

Since the parent takes it for granted that the child *has* to cry in order to make his wants known, there is ordinarily no effort on the part of the parent to look for other cues. After a short time the various responses alternative to crying as a means of communication tend to drop out and are superseded by crying as the preferred mode of communication left to the baby. Situations that in themselves do not specifically require crying thus acquire the meaning of distress, or are at least conditioned to the response of crying, because other modes of expression on the part of the infant have failed to bring about the relief of his wants.

One may state the argument schematically as follows:

I. Distress or pain leads to the unconditioned response of crying.

II. Want leads to unconditioned responses other than crying.

1. If heeded, these responses become reinforced and are used by the baby in the future.

2. If these cues are not heeded, the baby's wants increase to the point of distress and crying is again employed as the unconditioned response.

a. Then, as an *anticipatory* response, crying may be used by the infant on a *generalized* basis, even in mild states of want, in order to *prevent* distress. Thus the baby has learned to cry instead of having learned to use non-crying modes of communication.

The unconditioned responses other than crying are not difficult for the alert adult to recognize. The wants of the baby are simple and the language he naturally employs is equally simple. If the baby is hungry, he may smack his lips or eject his tongue; if he is cold, he may squirm or tremble; if he is wet, he may sneeze. Since being hungry or satisfied, cold or warm, wet or dry, and a few other elementary conditions exhaust the repertoire of the baby's needs, the signals that are germane to these situations can be readily learned by the attentive parent.

The baby learns to call at a distance in an unmistakable way, if such signals have been heeded with any degree of consistency by the attending adult. The variety of calls is

limited and one can discriminate fairly accurately the call of hunger, of wetness, and of other discomfort. The fretful tones of fatigue, when sleep is too slow in coming, are easily distinguished also. "Talking" in syllables to toy animals and to humans develops fairly rapidly.

At least one baby, at age five months, appears even to make a distinction between asking for milk, on the one hand, and for soft solids, on the other. As a signal for the former, she shows her tongue briefly in a licking motion. For soft solids, she audibly smacks her lips. Sometimes when milk is being given her by bottle, she stops sucking, pushes the bottle aside, and begins to smack her lips. When soft solids are then offered, this food is eagerly taken. Occasionally, when she is asleep past her usual feeding time, she has been observed to "talk in her sleep" by making one or another of these mouth movements. Here one may demur and insist that such fantasy behavior is autistic, not communicative in intent. But in the waking state the various signals above described are accompanied by intense concentration upon the face of the adult in attendance, so that the inference of communication is hard to resist.

One must not, however, expect that the baby who has been understood, as just noted, will never cry. In situations of pain or genuine distress, such as injury or illness, the infant will, of course, resort to the unconditioned response of crying. And when the infant successfully uses signals other than crying, crying as such in distress situations is far more meaningful than it would otherwise be.

Once the parent recognizes that crying is not the only mode of communication that the baby commands, and once this recognition has led to the attempt to understand the language of the baby, an important beginning in the understanding of the infant's growth as a whole has been made. It becomes evident that all the child's behavior has meaning and that this meaning can be understood by a receptive, sensitive, and interested adult. Under these circumstances one passes beyond the idea that the parent is expected to train the child to the corresponding expectation that the baby also trains the parent. The parent learns to understand the baby and assumes from the outset that the baby is understandable. On this basis the later attempts to train the baby to understand the adult world become far easier, since appropriate lines of communication

have been established from the beginning of life between the growing infant and his inherited social environment.

The advantages of teaching the baby not to cry—or, better said, of not teaching it to cry—consist, then, not only in the quieter atmosphere of the nursery, but in the amelioration of the baby's total growth toward healthful social relationships. Since being understood might almost be described as the basic need of man as a socialized animal, the importance of the parents' responsiveness to the infant's needs in the earliest days and months of life can hardly be exaggerated. If the child expects to be understood as a result of the parents' ability to understand signals other than crying, the effective communication thus early established becomes a source of security which facilitates growth in other directions as well.

The baby may well learn to postpone his impulsive wants far more rapidly than he otherwise would if the discriminative type of communication here described has been acquired; reassurance in words by the parent—perhaps the father—may well make it possible for the baby to wait until the mother can come. Not only is the parent understanding the communications of the baby under these circumstances, but the child may reciprocally learn at a very early age to understand the communications of the parent. Whether verbal language development as such is hastened by such mutual understanding is a question that deserves serious investigation. But the more important effects would certainly be those exerted upon the general emotional development and social learning of the infant.

The preceding discussion is intended to make clear the possibility that crying is a form of communication used by the infant on a general basis—rather than specifically in situations of distress—only if no alternative has been learned. One may restate the hypothesis thus: Crying as a generalized form of expression or communication is learned. There are actually other modes of unconditioned response by which the baby attempts to make his wants known, and the sensitive and alert adult can learn this language. In the event of successful learning on the part of the parent, the infant does *not* learn to cry as a generalized language. Instead, there is established between the parent and the baby a warm and sympathetic relationship that plays an important part in the entire development of the child.

THE INSTITUTE OF INTERPERSONAL RELATIONSHIPS IN PUBLIC HEALTH: AN EVALUATION *

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DURING the past several years, there has been a lively, even enthusiastic interest in the institute as a technique for teaching the principles and practices of "good" interpersonal relationships.

The word "institute" has acquired a new and rather specific meaning in this context. It refers to a concentrated learning experience at the postgraduate level. Characteristically, a student body composed of individuals with related professional backgrounds and interests, and faculty members trained in the various fields concerned with interpersonal relationships, spend the bulk of their waking hours together in a relatively status-free atmosphere, for periods ranging from one day to three weeks. The time is apportioned among lectures, demonstrations, and group discussions, formal and informal.

These are general requirements, and there are wide variation from institute to institute. Examples of this variation, as well as a general discussion of the institute as a teaching method, are very well presented in two monographs published by the Commonwealth Fund: *Teaching Psychotherapeutic Medicine,* edited by Helen Witmer, published in 1947; and *Public Health Is People,* by Ethel L. Ginsburg, published in 1950.

Retrospective judgments about these institutes have been mixed. Many of the sponsors have described a rosy glow of gratification, and an "intuitive feeling" that something "meaningful" happened. Each institute has been followed by its share of testimonials, solicited and unsolicited. Instances

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of important changes in attitude on the part of one or more of the participants are cited, with the implied assumption that this has been a direct result of the institute. Very frequently, fellow participants describe a very affectionate regard for one another. It is important to add that in many cases the sponsors or participants who make these judgments are of the hard-to-convince variety.

On the other hand, many people have remained skeptical. Among these are some who are highly sympathetic to the idea that the experience provided in a small and skillfully directed discussion group may be most fruitful as a means of learning about the dynamics of interpersonal relationships. The skepticisms are of many origins: the experience is too short; it is too removed from the reality of daily operations; it is too diffuse and unstructured, or it is too structured.

Agreement has been wide, however, that none of these casual retrospective judgments is reliable. The need for more precise evaluation has been expressed by enthusiasts and skeptics alike. The following study began as an attempt to explore some of the methodological problems involved in one type of evaluation—*i.e.*, the questionnaire.

The institute studied was that sponsored by the American Public Health Association prior to its annual meeting in St. Louis, October 28–31, 1950. It was entitled "Institute on Interpersonal Relationships in Public Health." There were 92 highly selected participants, 19 of whom acted as group leaders. An attempt was made to choose the remaining 73 from young individuals holding important administrative or training positions in voluntary or official health agencies. Professionally, the participants were grouped as follows:

Non-Faculty		*Faculty*	
Health educators	19	Psychiatrists	8
Public-health nurses	19	Public-health nurses	4
Health officers	18	Public-health educators	3
Sanitary engineers	7	Public-health administrators	3
Public-health administrators	3	Psychiatric social workers	1
Other	7		
Total	73	Total	19

The decision to attempt an evaluation of the St. Louis institute was not made until the spring of 1951. At this point,

we rediscovered that one of the most fundamental methodological demands of any evaluation is pre-planning. Two major areas require careful consideration—the selection of the participants, and the objectives of the institute. Clearly, these are not independent variables.

It may appear premature to assign specific objectives to a procedure as yet so young as the institute. It would seem doubly so if it were required that these objectives be measurable. Nevertheless, this is a prerequisite to evaluation. An assignment of measurable goals does not imply that these summarize all that may be accomplished. It is quite possible that the objectives to be evaluated may comprise only a fragment of the total accomplishment; and it may be a less important fragment at that. Findings that objectives have not been met do not permit the conclusion that nothing has happened. The only justifiable conclusion is that there has been no demonstration of accomplishment.

The selection of participants cannot be a casual matter. No valid evaluation can be made without at least one control group. The composition of this group may vary, depending upon the nature of the institute and the substance of the objectives; and, of course, it must resemble the study group in all pertinent variables. Accordingly, both the method of selection and the final composition of the study and control groups cannot be haphazard matters.

The St. Louis institute was not preceded by the above kind of planning; and it may well be asked why we proceeded with the study. Here we drew upon the time-honored precedent of the exploratory investigation, the "pilot study." It was our hope that we might learn some things that would facilitate subsequent evaluations. Further, we thought we might be able to make some qualitative estimate of the St. Louis institute.

Procedure.—The study began with a request to all the group leaders for suggested items to be included in a proposed questionnaire. The majority of the suggested questions reflected similar interests, orientations, and curiosities: What, if anything, did the participant believe he had gained? What specific components of the institute were most productive? Least productive? What suggestions could be made to enhance the effectiveness of the institute? The final questionnaire was

largely a product of the proposed items, organized, consolidated, reworded, and coded. The questions varied widely in style. Some were tightly structured and forced the answers into one of several choices. Others were nearly open-ended, and encouraged a more anecdotal type of response.

We found the latter type of question particularly difficult to code. This was not surprising, and a certain amount of arbitrariness and compromise is accepted as unavoidable in the coding of such material. However, the problem was compounded in this instance by the absence of stated objectives for the institute. Fortunately, however, both the material prepared in advance of the institute and the summaries of the proceedings during the institute were sufficiently unambiguous to allow us to state the objectives after the fact, and this without undue manipulation and squeezing.

In summary, the intended focus was on more productive and comfortable working relationships with colleagues. This focus was to be established and sustained by a few lectures, by an opportunity to discuss the problems of such working relationships in small groups, and, importantly, by a demonstration—via the very conduct of the institute—of a respect for the opinions and attitudes of all individuals.

It was *not* the aim of the institute to aid its participants in the search for the Good Life. It was not anticipated that enduring personal problems would be, could be, or even should be solved in such a setting. Further, it was scarcely believed that any problems of intra-staff relationships would be solved. The aim of the institute, a more modest one, was to stimulate the participants to seek out other similar learning situations, and to encourage their non-attending colleagues to do the same. In brief, the objective was to high-light an important problem, and to introduce a kind of experience that, if pursued, might aid in the solution of this problem.

We have described above the general outlines of the questionnaire design, and some of its underlying assumptions. However, since this report concerns itself as much with some of the technical problems of such an evaluation as with the findings of this particular evaluation, we have decided to discuss some of the detailed aspects of the design question by question, along with the results.

The final questionnaire was long and looked rather for-

bidding. We estimated that between thirty and sixty minutes would be required to complete it. We knew that these factors were not likely to diminish the usual difficulties experienced in obtaining a usable return. However, we resisted any further abbreviation of the questionnaire on the grounds that we were working with a highly selected professional group, one from whom more participation could be expected than from a group randomly selected from the general population. This surmise proved to be justified.

The usual devices were employed to encourage prompt and critical answers: an explanatory covering letter, self-addressed stamped envelopes, follow-up special-delivery letters, and telegrams. However, the indispensable ingredient was stubborn, even irritating persistence. At least ten of the questionnaires were returned with letters which began somewhat as follows: "All right—you asked for it. I'm finally convinced that you want to know what I think, so here goes. . . ."

General Response to the Questionnaire.—Of the 73 questionnaires mailed, 60 were returned. Of the 13 who did not answer, seven could not: two had been present for a small portion of the institute only and did not feel qualified to answer; two were on extended sick leave; and three had moved, and no forwarding address was known. Thus 60 of 66 possible returns were obtained.

The six non-respondents did not show any conspicuous features in common. They came from all the professional groups represented except health officers, and from four of the eight discussion groups. Three of the six did come from one of the discussion groups; but although the temptation to speculate is great, the numbers are small.

The distribution of replies according to time received is shown in the tabulation below. In this tabulation, and some of the others in this report, the results have been given under the headings "Group A" and "Group B," as well as under "Total." The two subheadings were derived in the following fashion: The last question on the schedule asked whether the participant would now decide to come to the institute, knowing in advance what it would be like. Thirty-seven people checked "yes, definitely"; they constitute Group A. Twenty-three checked either "yes, probably," "probably not," or

"definitely not"; they constitute Group B. Our working hypothesis was that this breakdown might usefully separate the enthusiasts from the skeptics. If this were so, we could then ask: For what kinds of question does this distinction seem important? If there are any, it would be helpful to include such a question on subsequent evaluations. A comparison was made between these groups on each of the questions, using a Chi-square technique, and, where indicated, Yate's modification for small numbers. Where no mention is made of this in the tabulations, no significant difference was observed.

The difference between groups A and B appears to be a real one. Those who were most enthusiastic answered more promptly. This phenomenon has been reported elsewhere in a number of questionnaire surveys.

DISTRIBUTION OF REPLIES ACCORDING TO TIME RECEIVED

Week after 1st mailing	*Group A*	*Group B*	*Total*
1	2	1	3
2	13	1	14
3	2	1	3
4	4	3	7
Follow-up letter			
5	2	2	4
6	4	3	7
7	1	3	4
8	1	2	3
9	3	4	7
10	0	0	0
11	2	0	2
Follow-up telegram			
12	3	3	6
	37	23	60

No constant relationship was observed between time of response and the profession of the respondent, or the particular discussion group of the respondent.

The Questions and Answers.—The questions as they appeared on the questionnaire, and the answers to them, coded into categories [1] that were devised before the questionnaires

[1] The categories did not appear on the questionnaire unless they are enclosed in quotes.

were returned, except in the case of those marked with an asterisk, were as follows:

Question 1: "In retrospect what, for you, was the key idea derived from the institute?"

This was one of the two most "open" questions in the questionnaire. It was designed, as was the other, to tell us the degree to which the participants agreed with the planners as to the major focus of the institute. To minimize any influence that other, more specific questions might have exerted, this question was placed at the beginning of the questionnaire.

We have received criticisms that this first question, particularly in view of its prominent and, therefore, possibly "tone-setting" position, was not "open" enough. The wording implies that a key idea *was* derived, and it is said that the question is loaded. The loading was deliberate. In view of the purpose of the question, some forcing of the answer seemed to be justified. We were not asking for the participants' judgment of the key idea; they might well regard it as a thoroughly useless one. But we did want to know how each participant perceived the orientation of the institute. We hoped that this would not slant the answers to the remaining questions. The quality of the response leads us to believe that we were successful in this, but we cannot be sure.

RESPONSES TO QUESTION 1

Key idea	*1st idea mentioned*	*2nd idea, if any*	*Total*
1. Related to personal problems	0	0	0
2. Related to relationships with family and friends	0	0	0
3. Related to relationships with staff	33	1	34
4. Related to relationships with "public"—*i.e.*, patients, students, etc	1	1	2
5. Related to conduct of institutes	5	2	7
6. Related to general interpersonal relations	15	3	18
*7. Related to recognition of scope of problem	4	1	5
8. No answer	2	52	..
	60	60	..

* Category not devised before questionnaires were returned.

It was of interest to us that the responses fitted easily into the pre-assigned categories. This undoubtedly was partly due to the relative diffuseness of the categories and to our own preconceived notions. However, part of this ease of coding may

have been a reflection of the often observed practice of seizing upon well-turned phrases, a few of which apparently received extensive use during the course of the institute.

The findings suggest that the institute succeeded fairly well in maintaining the desired orientation—*i.e.*, intra-staff relations. No one thought that the occasion was primarily directed toward the solution of personal problems. It is also interesting that so few high-lighted the conduct of the institute as being of key importance. This relative indifference to type of procedure is also apparent in the results of the next question.

Question 2: "Looking back on the institute, what stands out as having been of greatest value to you in your work or in your relations in general?"

This question is even more loaded than the first. Here we asked for a qualitative as well as a quantitative judgment. Our purpose, thinking, questions, and misgivings were similar to those in regard to Question 1; but the misgivings as to the degree to which subsequent answers might be slanted were a little more profound. Again, we think the bias contributed was slight, but again we cannot be certain.

RESPONSES TO QUESTION 2

Items	*1st item mentioned*	*2nd item, if any*	*Total*
A. The trip:			
1. The vacation from work	0	0	0
2. The site	0	0	0
3. The "extra-curricular activities"	0	0	0
B. The form of the institute:			
1. The lectures	1	1	2
2. The group discussions	2	1	3
3. The after-hours "bull sessions"	7	0	7
C. The content:			
1. Idea relating to personal well-being	0	1	1
2. Idea relating to intra-staff relations	23	5	28
3. Idea relating to public relations	1	3	4
*4. Idea relating to "general" interpersonal relations	10	1	11
*5. Idea relating to "scope of the problem"	2	2	4
*6. Idea relating to the conduct of institutes	1	1	2
D. The contacts:			
1. The fellow participants	6	0	6
2. The "faculty"	2	1	3
E. No answer	5	44	..
	60	60	..

* Category not devised before questionnaires were returned.

These data strengthen the notion that content superseded form in the opinion of the participants, and that problems of intra-staff relationships dominated the content.

Question 3: This question was twofold:

A. "On the whole, what effect did the institute have on your knowledge of the field of mental health and interpersonal relations?

"Increased my knowledge considerably.
"Increased my knowledge slightly.
"Hardly any effect or none at all.
"If some increase, please describe in what respects."

B. "On the whole, what effect has the institute had on your skills in the field of interpersonal relations—*e.g.,* in supervising the work of others, participating in group activities, etc.?

"Increased my skills considerably.
"Increased my skills slightly.
"Hardly any effect, or none at all.
"If you feel your skills were increased, please describe in what respects."

RESPONSES TO QUESTION 3A

	Group A	*Group B*	*Total*
Increased my knowledge considerably	18	3	21
Increased my knowledge slightly	15	13	28
Hardly any effect or none at all	2	4	6
No answer	2	3	5
	37	23	60

Area of increase described:	*1st item mentioned*	*2nd item, if any*	*Total*
1. Personal insight	5	3	8
2. Staff relationships	6	5	11
3. Community relationships	4	0	4
4. Acquaintance with "the authorities" in the field	3	0	3
5. Acquaintance with a teaching method in mental hygiene	3	1	4
*6. General statement about knowledge of interpersonal relations	14	0	14
*7. Recognition of the scope of the problem	5	0	5
8. No answer	20	51	..
	60	60	..

* Category not devised before questionnaires were returned.

RESPONSES TO QUESTION 3B

	Group A	*Group B*	*Total*
Increased my skills considerably	10	2	12
Increased my skills slightly	21	13	34
Hardly any effect or none at all	3	6	9
No answer	3	2	5
	37	23	60

Area of increase described:	*1st item mentioned*	*2nd item, if any*	*Total*
1. Personal comfort	1	0	1
2. Easier communication with colleagues, friends, etc.	1	1	2
3. Increased tolerance of personal differences	4	0	4
4. Modification of expectations of others	4	3	7
5. Ability to lead a group discussion	3	0	3
6. Ability to supervise the work of others	9	4	13
*7. General statement about "skill in interpersonal relations"	11	2	13
*8. Skill in a teaching method in mental hygiene	3	1	4
9. No answer	24	49	..
	60	60	..

* Category not devised before return of questionnaires.

The first two questions forced each participant to rate the various aspects of the institute against one another. The answers, however, could not be used to make any quantitative comparisons among groups of the participants. For example, of two individuals describing the key idea as one relating to relationships with staff members, one might have regarded this as being of great value, and another, of very limited value. The two parts of Question 3 were designed to force judgments of the entire institute into the same semi-quantitative scale, thus allowing a gross over-all appraisal, and perhaps some comparison between groups of the participants.

Several general conclusions may be drawn. A surprisingly small number thought that they had learned little or nothing, and had enhanced their skills minimally or not at all. On the other hand, roughly a third thought that their knowledge had been considerably increased, and a fifth, their skills. When the findings were considered under the headings "Group A" and "Group B" it was clear that those in Group A thought that they had gained more than did those in Group B; but the difference was not statistically significant at the 2 per cent level.

However, when the data from the two parts of the question were combined, Chi-square was found to be 11.04; and with three degrees of freedom, the value of $p = 0.012$. That is, if there were truly no difference between groups A and B, the observed difference would be likely to occur by chance alone only 1.2 per cent of the time. This suggests strongly that the two groups were truly different. It still does not allow us to say that one is more or less critical, more or less "right" than the other.

Question 4: This question also was in two parts:

A. "With respect to the following areas or activities, check to indicate whether you have spent more, less, or about the same amount of time and energy during the past year than during the previous year."

B. "With respect to the following activities, check to indicate those in which you have been more, less, or equally successful during the past year than during the previous year."

Probably the most crucial, and often the most difficult, part of the evaluation of any procedure is the demonstration of resulting change. It was particularly in this area that we felt the pinch caused by the absence of any pre-institute studies. We immediately reconciled ourselves to the limited objective of trying to estimate *any* change; to prove that such change was a probable result of the institute was accepted as impossible.

Question 4 was the only one in the study specifically designed to force estimates of movement by the participants. Such estimates are subject to critical biases of several sorts. All of us are more likely to report changes consistent with our self-images. Sometimes this image is a deprecatory one; sometimes it is favorable; the images vary widely in the degree to which "undesirable" qualities are permitted to appear. Further, to varying degrees, our preconceived views of the procedure itself, and our attitudes toward those conducting the procedure, may influence our estimates. Finally, if it is assumed that some changes might have occurred, these very changes may have altered the retrospective judgments, and shaped the memory of the participants experiencing the change.

Some efforts were made to minimize the effect these biases

might have on our conclusions. The questions were worded in a manner calculated to minimize any responsibility the participants might feel to defend the institute or its faculty. Mention of the institute was avoided; and the period mentioned did not coincide with the time elapsed since the institute. (The questionnaire was returned between seven and ten months after the institute was held.) There was no serious objection to this, because we were not trying to prove that any movement observed was a product of the institute itself. We are not at all sure, on the other hand, that it served in any way to minimize the bias. Coming as it does in the middle of a questionnaire, which in all its other portions shouts its affiliation with the institute, it is likely that this question was similarly identified.

We employed another technique in an attempt, not to affect, but to estimate the bias. Of the 15 items to be rated in Question 4, seven (those marked with a †) were selected because we thought them possible areas of change—*i.e.*, consistent with the objectives set for the institute. The remaining 8 were selected because they possessed two qualities: in our judgment, an unlikelihood of change as a result of the institute, and yet sufficient resemblance to the other seven items

RESPONSES TO QUESTION 4A

Activities or areas listed:	*More time*	*Less time*	*Same amount*	*No answer*
†1. Participating in group discussions of interpersonal relations	31	3	24	2
†2. Attending lectures, institutes, or workshops in the field of interpersonal relations	14	10	33	3
3. Disagreeing openly with your colleagues in administrative policy	13	20	19	8
4. Reading technical journals in your own specialty	15	2	40	3
†5. Obtaining guidance or treatment for personal problems in the field of interpersonal relations	14	3	36	6
†6. Analyzing your own feelings in respect to group activities	49	0	9	2
7. Pursuing selfish interests at the expense of others on your staff	0	27	22	11
†8. Promoting group discussions of interpersonal relations	34	2	20	4

† Possible area of change.

RESPONSES TO QUESTION 4B

Activities listed:	*More successful*	*Less successful*	*Same*	*No answer*
1. Supervising the work of others.....	39	2	16	3
†2. Organizing your reading in the field of interpersonal relations	18	2	38	2
3. Working out your personal problems in the area of interpersonal relations..	38	0	19	3
4. Speaking at a public meeting.....	17	3	37	3
5. Working amicably and productively with your colleagues.....	35	0	23	2
†6. Participating in the planning for training of your colleagues in the field of interpersonal relations	28	2	27	3
7. Keeping well-informed in the area of your own specialty.....	20	2	35	3

† Possible area of change.

so that overoptimistic participants might describe change. In short, we attempted to create a reference point from which to judge bias by pooling our own preconceived notions. We thought to estimate an unknown bias through use of a known one. As the responses indicate, we were only questionably successful at best.

The data for each item speak for themselves. It is noteworthy that there was greatest agreement on item A-6. Forty-nine of the 58 individuals answering said that they spent more time analyzing their own feelings above group relations. We were surprised to find that there was in general as much change described in the "unlikely" items as in the "likely" ones. Does this mean that the group was too optimistic, or that we were too pessimistic? The evidences we have are these:

1. The scores for those in Group A ("definitely yes") and Group B were compared, using a Chi-square technique, item by item. In only one instance was a statistically significant difference observed—A-3 ("Did you spend more, less, or about the same amount of time and energy during the past year than in the previous year disagreeing openly with your colleagues in administrative policy?"). This was one of the questions that we had thought concerned an area unlikely to show change as a result of the institute. Further, our preconceived notion was that whereas a desirable change might

well be in the direction of *more* open disagreement, less critical participants might assume that the opposite was true and answer accordingly. The data on this item, by groups, were as follows:

Time spent	*Group A*	*Group B*	*Total*
More	10	3	13
Less	17	3	20
Same	8	11	19
No answer	2	6	8
	37	23	60

Participants in Group A described change more often (27 of 35 answering) than did those in Group B (6 of 17 answering). Of those in Group A who described change, most (17 of 27) said that they were disagreeing openly less often; fewer in Group A hesitated above answering such a question. These findings suggest to us that those in Group A may be less critical; and possibly they erroneously assumed that a "sweetness and light" philosophy of staff relations was being espoused, and so answered.

2. A comparison was made of the percentage of unanswered questions by groups. In the groups combined, altogether 60 individuals, 56 of the total of 900 questions (60 times 15) were unanswered—6.2 per cent. In Group A, 2.2 per cent were unanswered; in Group B, 12.8 per cent were unanswered. If it were assumed that 6.2 per cent was the true value of both groups—*i.e.*, that there were no differences—the likelihood that such an observed difference could have occurred by chance alone would be extremely low—less than one time in a thousand. Group B was more cautious, less ready to commit themselves. This, too, is a bias, but a safer kind of bias in an evalaution of this sort.

3. The data from groups A and B were pooled into the two major groups of these 15 questions—*i.e.*, those regarded by us as possible areas of change, and those regarded as unlikely areas of change. With each of these groups of questions, groups A and B were found to be different to a degree that was statistically significant. However, as demonstrated above, there was a real difference in the percentage of unanswered questions in the two groups. If the contribution of this item

is ignored in the summation of Chi-square, it is found that the difference between Group A and Group B, in the questions thought to indicate possible areas of change, disappears; but the difference remains intact in the other group of questions. We think this suggests that, aside from the already demonstrated difference in the percentage of unanswered questions, groups A and B estimated approximately the same kinds of change in the areas thought to be possible of change from such an institute, but that Group A was more likely to describe such changes in areas that we regarded as beyond the scope and purpose of the institute.

In general, we can draw the following conclusions: A surprisingly high degree of change was described in a number of the questions. These changes allegedly occurred in areas considered by us as unlikely to show change as a result of the institute as well as in those more consistent with our limited objectives. However, the group of participants who are more cautious—and, we think, probably more accurate—in their appraisals, described change chiefly in the latter area.

Question 5: "Did you find yourself upset emotionally during any of the general or group sessions? Please check below." Four possible choices were listed on the questionnaire.

Several people who had participated in the planning of the questionnaire had thought that it would be important to know something about the emotional experiences of the participants during the institute, but they doubted that many would be willing to describe these experiences. Question 5 was designed to test this point. The replies were:

I did not feel upset at any time	29
I felt upset on one occasion	16
I felt upset several times	11
I felt upset during most or all of the sessions	2
No answer	2
	60

Question 6: "Suppose you were given the task of planning another institute. How would you answer the following questions?"

This set of seven questions had a dual purpose: to get

information that might be helpful in the planning of a subsequent institute; and, indirectly, to obtain opinions about this institute. Unless otherwise indicated, all the parts of this question were of the multiple-choice variety, and the choices all appeared on the questionnaire.

A. The answers to the first question under 6—"What kind or kinds of professional person should lead the discussions?" —were grouped as follows:

Profession	*Number of persons choosing*
Psychiatrist	16
Sociologist	6
Experienced administrator	12
Public-health educator	4
Psychiatric social worker	5
One who has had experience in leading groups, no matter what his professional background	44
Other	3
No answer given	1

One of the choices was obviously presented in a very leading fashion ("One who has had experience in leading groups"), and this may account in part for its popularity. Even so, it is interesting that so many felt that specific professional training was not an important requirement for a group leader. These groups, it is clear, thought that their function was discussion, not therapy.

B. The second question—"What size discussion groups do you consider ideal?"—brought the following replies:

6 or less	3
7 to 10	32
11 to 15	19
16 to 20	3
More than 20	0
No answer	3
	60

The actual sizes of the groups, including the leaders, ranged from nine to thirteen. Fifty-one of the 57 participants who answered this question thought that this was as it should be.

C. The answers to the third question—"What proportion

of total institute time should be spent in group discussions? . . . To aid us in interpreting this: in retrospect, what proportion of the last A.P.H.A. Institute do you think was devoted to discussion?"—were given in percentages, but are here coded as "More,"—*i.e.,* those who wanted more discussion time than they remembered having—"Less," and "Same."

More	14
Less	17
Same	24
No answer	5
	60

D. "Should the members of the discussion groups represent the same or different professions?" the fourth item under Question 6, brought replies as follows:

Same	3
Different	51
No answer	6
	60

E. The replies to the fifth item—"In an institute associated with a national meeting, such as that of the A.P.H.A., how short can it be and yet remain potentially valuable?"—showed the following grouping:

One-half day	0
One day	7
Two days	31
Three to five days	18
Six or more days	1
No answer	3
	60

The actual duration of the institute was two days.

F. The sixth item was: "With respect to the following qualities, check whether you think they would be unimportant, moderately important, or very important criteria in the selection of participants in the institute. Your selection of a quality as 'important' will not be interpreted as indicating that you would insist that *all* the candidates be judged on this criterion." The replies were:

	Very important to include	*Moderately important to include*	*Relatively unimportant*	*Moderately important to exclude*	*Very important to exclude*	*No answer*
1. Administrative responsibility with wide area of influence..	35	16	5	0	0	4
2. Difficulties in personal relationships with colleagues.....	23	13	12	4	2	6
3. Skeptical attitude toward institutes such as these.....	14	10	15	12	3	6
4. Responsibility for training.....	45	9	1	0	0	5
5. Over forty years old.....	9	8	38	1	0	4
6. Experience in previous similar institutes.....	10	11	29	5	0	5
7. Administrative responsibility in a group which has only local influence.....	19	23	13	1	0	4
8. No immediate likelihood of assuming a position of leadership	8	8	23	13	4	4

The composite ideal participant, as induced from these responses, is an individual with widely influential administrative responsibility, or one who is active in training. Only 6 of 54 would exclude him if he had difficulties in personal relationships with colleagues; and 36 of 54 think the institute may be of some value for such a person. Only 16 of 54 would include one unlikely to assume a position of leadership in the near future.

G. "What specific focus would you recommend for subsequent institutes?" was the last question under 6. The coding of the answers did not appear on the questionnaire, and the same coding was employed as was used in Question 1.

Recommended focus	*1st idea mentioned*	*2nd, if any*	*Total*
1. Related to personal problems.....	0	1	1
2. Related to relationships with family and friends	0	0	0
3. Related to relationships with staff.....	18	1	19
4. Related to relationships with "public"—*i.e.* patients, students, etc.....	5	2	7
5. Related to conduct of institutes.....	19	0	19
6. Related to general personal interrelationships...	9	4	13
7. No answer	..	..	9

Question 7: "If you knew prior to the Institute what you know now, would you attend?" The answers were:

Yes, definitely	37
Yes, probably	14
Probably not	8
Definitely not	1
	60

The above data are not without some value. A number of fairly solid conjectures can be drawn from them:

A. About this institute:

1. a. A fairly circumscribed focus on problems of intra-staff relationships was maintained.
   b. The participants did not view the occasion as one designed for personal psychotherapy. However, of 40 individuals who described the area of the increase in their knowledge of the field of mental health, 8 mentioned enhancement of personal insight.
2. a. Both knowledge and skills in the field of mental health were somewhat increased during the institute.
   b. Skills were less affected than knowledge.
   c. Group B described less change than Group A.
3. a. The institute was followed by a heightened awareness of the importance of emotions and of interpersonal relations for intra-staff relationships.
   b. Further, apparently more time has been spent by the participants since the institute in promoting group discussions of interpersonal relations.
4. a. The participants liked discussion groups led by people experienced in such activities, no matter what their profession.
   b. The size of group preferred was relatively small—about 7 to 15, and composed of members representing different professions.

c. There were mixed opinions as to the relative amount of emphasis to be placed on discussion, as there were on the duration of the institute. Nineteen of 57 individuals would have lengthened it.

5. The institute was regarded as a somewhat precious commodity, to be reserved for those in responsible positions; and since the participants were people in just such positions, we may surmise that they thought the experience to have been an appropriate one for themselves.

B. About the method of the study:

1. A questionnaire is a feasible device with which to gather a complex array of confidential information when the studied group is drawn from a responsible—*e.g.,* professional—group.
2. The spectrum of attitudes toward such a questionnaire, even among members of such a group, ranges from eager enthusiasm to grumbling acquiescence. And to obtain the views of the less zealous, it is necessary to make something of a nuisance of one's self.
3. It does not suffice to gather the easy answers, and to generalize from these alone. The opinions of the obdurate were found to be more reserved and skeptical; and the frankly critical were all found in this group.
4. It may be possible to build into the questionnaire items that can identify those individuals whose judgments are more considered.

These statements have been labeled as "conjectures" rather than "conclusions"; in our opinion, that is all that our data warrant. This very inconclusiveness of the data, however, cannot be attributed chiefly either to the unwillingness or to the inability of the participants to provide it, or to the inadequacy of the questionnaire method to gather it. Rather, the difficulty resides in the total experimental design. Our experience with this study has led us to several decisions,

by no means novel ones, about modifications that we would make were we to conduct another. In many settings, these modifications would not be feasible. This should not discourage one from holding an institute, but it should discourage one from trying to evaluate it in a definitive fashion. We would modify the procedure in the following areas:

1. Select operationally definable objectives before the institute is held. The hypothesis to be tested in the evaluation would then be: If the objective is attained for any participant, his future behavior, broadly defined, will change in certain specific areas to a degree significantly different from that observed in a valid control group.

   a. This does not necessarily preclude the presence also of currently unmeasurable major objectives, but these could not be included in the evaluation.

   b. It is worth reiterating that a negative finding denotes only a failure to *demonstrate* accomplishment.

2. Specify the criteria by which participants are to be selected.

3. Choose a control group that is comparable in all pertinent regards.

4. Information about those pre- and post-institute activities of the study and control groups which are germane to the evaluation must be available.

5. If possible, select for study an institute whose participants are from a relatively circumscribed geographic area. More precisely, it would be useful if a sample, if not all, of the participants could be interviewed personally as part of the follow-up observation.

In making these recommendations, we have been begging the question—in fact, a multitude of questions. How does one select and validate the array of "behaviors" that, summed, approximate the stated objective? How does one insure the appropriateness of the control group? How is the latter to be used? Should it constitute a "before" group, to be compared with a participant "after" group? Should both be studied before and after, or after only? How can a pre-institute base line be constructed without affecting either the perceptions of the institute itself or the validity of the follow-up studies? We submit that there is no single answer to

any of these questions, that the particulars of any study critically effect the detailed mechanics of question design, control-group selection, and so on. However, the questions *are* answerable within the context of a single study.[1]

Not every institute can be or need be appraised; and not every appraisal can be or need be a rigorous evaluation. There is a value in the conjecture, frankly labeled as such. Those that we have been able to make shed some light on the St. Louis Institute and provide hypotheses that can be tested in future evaluations. However, if a more reliable evaluation is to be achieved, we urge careful consideration of the above-described areas of study design.

[1] For an excellent and documented discussion of these points, see *Research Methods in Social Relations*, by M. Jahoda, M. Deutsch, and S. W. Cook. New York: Dryden Press, 1951.

VOCATIONAL REHABILITATION IN A PSYCHIATRIC HOSPITAL: AN INITIAL REPORT

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THE psychiatric hospital performs many functions and renders many services in its attempt to restore the patient to effective mental health. The vocational-rehabilitation services, though they are a small part of the total psychiatric program, can, nevertheless, be helpful in returning and readjusting the patient to the community. It is our purpose here to emphasize the availability of these vocational services as well as their utilization since, until now, most psychiatric hospitals have made little use of them.

State vocational-rehabilitation agencies, receiving grants-in-aid from the Office of Vocational Rehabilitation, Federal Security Agency, are operative in each state, in Puerto Rico, Alaska, and Hawaii. The federal government matches the amount of funds appropriated by each state for the various kinds of service considered necessary to rehabilitate disabled individuals. Although the Office of Vocational Rehabilitation provides medical, psychiatric, and other professional consultative services to the state vocational-rehabilitation agencies, each state is wholly responsible for the administration of its program.

The original vocational-rehabilitation act for civilians was passed in June, 1920. In 1943, Public Law 113, which amended the original act, established a comprehensive state-federal program. It was under the terms of the 1943 amendments that rehabilitation services were extended to persons with mental disabilities. To be eligible for these services, an indi-

vidual merely has to have a physical or mental disability that constitutes a substantial employment handicap.

There has accrued from the state-federal vocational-rehabilitation program not only a social gain in the better adjustment of the disabled person, but also an economic gain. This is strikingly evidenced by the fact that in 1951, state vocational-rehabilitation agencies throughout the nation rehabilitated back into employment 66,193 persons whose annual rate of earnings after rehabilitation was in excess of 100 million dollars. Two thousand, six hundred, and ninety-one of these persons had been disabled by mental and emotional disorders. At the time when these 2,691 persons made application to the state vocational-rehabilitation agencies for rehabilitation services, 61 per cent had a diagnosis of psychoneurosis, 23 per cent of psychosis, 5 per cent of psychopathic personality, and 11 per cent of "other." After rehabilitation, these 2,691 individuals were placed in jobs in nine different major occupational classifications—*e.g.,* 23 per cent were placed in clerical positions; 9 per cent in professional, semi-professional, and managerial positions; and 6 per cent in sales and related positions.

In the commonwealth of Pennsylvania, during the 1951–52 fiscal year, 3,352 physically and mentally disabled clients of the state vocational-rehabilitation agency were successfully rehabilitated and placed in employment. It is estimated that the employment of these 3,352 persons has increased the over-all income in the state by approximately 5 million dollars.

The question arises as to the definition of a handicapped psychiatric patient. To the Federal Office of Vocational Rehabilitation, the psychiatric patient is considered handicapped: (1) if employment has been terminated as a result of his mental condition; (2) if prolonged convalescence or unemployment has resulted in the deterioration of skills or performance in his occupation, thereby necessitating some modification of that occupation; (3) if he requires special consideration to avoid employment that is likely to aggravate his mental condition, create a hazard to his future health and safety, or jeopardize the health and safety of others; (4) if his disability interferes with his preparation for an occupation commensurate with his capacities or with his attainment of

the experience necessary for entering into such occupation; and (5) if because of the disability there is employer's refusal or reluctance to employ the individual, or refusal or reluctance of the other employees to work with him.

This broadening of the scope of vocational rehabilitation is in keeping with the ultimate development of emphasis not merely upon the disabled, but upon the severely disabled. Furthermore, when one recognizes the high incidence of mental illness, it becomes apparent that a community cannot afford to fail to plan for the selective utilization of existing job skills or the development of new skills in a great number of discharged psychiatric patients.

An attempt to determine jointly the best method of implementation of these vocational-rehabilitation services in a psychiatric hospital is currently being made by the Norristown State Hospital, Norristown, Pennsylvania, and the Pennsylvania Bureau of Rehabilitation. In the original meeting called to plan for this pilot demonstration, attended by representatives from the bureau of mental health, the bureau of rehabilitation, and the Norristown State Hospital, it was recognized that any proposed plan for the patient has the dual objective of restoration to employment independence and of prophylaxis against recurrent emotional breakdown.

After the formulation of a plan of action, the bureau of rehabilitation made its services available to selected convalescent psychiatric patients. These comprehensive vocational services include: vocational psychological testing; physical and surgical remedial measures; job counseling; job exploratory study; on-the-job training; pre-vocational training; vocational training; auxiliary training service; board, room, transportation, and so on; job placement; employment maintenance; and job-placement follow-up.

The restoration services that have been mentioned may be those of prosthesis (the supplying of artificial limbs, dentures, and so on) or a series of psychotherapeutic interviews after separation from the hospital. In short, the bureau of rehabilitation, after establishing financial need, offers any services necessary to reduce or, if possible, to remove the handicap, in order that the individual may enter competitive employment on a more equal footing. And this must necessarily be a job

that capitalizes on his remaining assets and minimizes his limitations in terms both of working duties and of working conditions.

It was naturally difficult to select the appropriate types of psychiatric case for this service. Those patients who had been psychotic, but who had reintegrated to the point of no longer needing hospital care, were referred to the bureau of rehabilitation. These cases were generally of two types: (1) those with special occupational skills who needed selective job placement; and (2) those with no occupational skills, but with many potentialities, who needed vocational training.

The hospital procedure for referring a case to the rehabilitation counselor is briefly this: Psychiatrists select appropriate patients who are then referred to a psychiatric social worker. The social worker sees the patient for an exploratory period, during which time a relationship is established that may be used later on in working through psychiatric problems. During this exploratory period the rehabilitation counselor gets all the information he can from the hospital and other sources as to the potential of the individual for training or placement. By bringing his potentials and his limitations into the patient's plan (in terms of current labor demands) the rehabilitation counselor helps the patient to work out his own vocational objectives. Where vocational training is indicated, that training may be entirely sponsored by the bureau of rehabilitation, with continuous supervision provided by the counselor. If immediate job placement is indicated, then direct, personalized placement assistance is given, followed by supportive supervision after the patient is on the job.

Since August, 1951, when the pilot demonstration was begun at Norristown State Hospital, 53 cases have been referred to the rehabilitation counselor. Of this total, 15 are now in suitable employment, 9 are being sponsored in vocational-training programs, 4 are being considered for vocational training, and 15 are being considered for job placement. In addition, one is being considered for occupational-tools purchase. The remaining 9 cases have been out of the hospital for varying lengths of time, but have had to be returned because of recurrence of the psychosis.

Two cases in this group illustrate the services better than a lengthy description. In both these cases there has been

notable success. It is felt that the help of the rehabilitation counselor has greatly aided these two patients in bridging the gap between the hospital and the community.

D.M., a thirty-seven-year-old man, has been in vocational training. He had a schizophrenic psychosis which began about 1937. He entered Norristown State Hospital in 1940 and from that time gradually improved, although there were frequent setbacks. During the last four years of hospitalization, he made a good work adjustment, but socialized poorly, retained some innocuous delusions, and was afraid to leave the hospital. In his early contacts with the rehabilitation counselor, he showed only minimal interest in the discussion as well as contrary feelings about work preferences. Psychological testing revealed superior intelligence; vocational testing, that he was currently capable of functioning in office practices as well as many clerical workers already in employment.

In order to evaluate the test results in a training situation, he was given a trial period in a local business school. This trial was very satisfactory in terms of academic performance, social adjustment, and better motivation. On the basis of this the bureau of rehabilitation underwrote the costs of a 72-week general office-training course. For the first ten weeks of this training, D.M. continued to live at the hospital and commuted to school. After that he lived in the community near the school, with full maintenance provided by the bureau.

During this training period there has been close supportive supervision by the rehabilitation counselor and the psychiatric social worker, each in his own professional area. At one point D.M. required extensive dental care; this was provided by the bureau in order to assure regular school attendance and minimal interference with his training pursuits. He has now performed satisfactorily in this training situation for over a year. His earlier indecision and lack of interest have been replaced by decisiveness, self-confidence, and good motivation.

K.M., a twenty-seven-year-old man, is in job placement. He had a schizophrenic psychosis which started about 1943. After a period at another hospital, he came to Norristown in 1947. Here he improved and was able to leave after one and one-half years. He worked for several months, but had a recurrence of psychosis and was returned to the hospital.

Two years later he was ready to leave the hospital again, but this time was referred to the bureau of rehabilitation. He wanted vocational placement even though he recognized his lack of adequate training. Testing showed that he had clearly defined interests and abilities in art and commercial fields. To meet his needs, immediate employment was secured. An appropriate position has offered him the opportunity to learn on-the-job bookkeeping and his many duties of stock accounting, sales, and so on, are sufficiently varied to meet his desires. His art interests have continued on an avocational level. He has had this job over a year and is very much pleased with it. He is liked by his employer who has given him several salary increases.

In summary, it must be emphasized that vocational rehabilitation is by no means a panacea for mental illness, but rather one of the necessary, albeit neglected, steps for the return of

the psychiatric patient to the community. Furthermore, it is a positive attempt, a positive act, to ensure his remaining in the community. But in coming to grips with the problem of rehabilitation of the psychiatric patient, it is evident that further exploration is justified. No final, time-tested conclusions are being offered here, but it is submitted that there is much basis for encouragement and much to indicate that vocational rehabilitation should be given a much wider trial in many more psychiatric hospitals.

The reasons for the reluctance of psychiatric hospitals to undertake these programs are not at all clear. It is quite possible that there has been inadequate circulation of information on vocational rehabilitation. It is also possible that there has been a lack of initiative on the part of the psychiatrist, coupled with a lack of experience in the psychiatric field on the part of the rehabilitation authority. Perhaps, also, the psychiatrist and the rehabilitation authority look on the traditional reluctance of the employer to hire a psychiatric patient as too great an obstacle.

In our brief experience it has been evident that vocational rehabilitation is a step forward and a blow against fear, ignorance, and wasted man power. It has been most gratifying to us to see acceptance of a man for a job he can do, instead of rejection of him because he has had a mental illness.

WHAT BECOMES OF THEM? *

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DURING the last five years, an average of 3,012 Jewish patients have been admitted annually to the psychiatric wards of Bellevue Hospital, New York City. This group includes men from the boroughs of Manhattan and the Bronx and women and children from all the boroughs of Greater New York. In studying the statistics of admissions and discharges both of the Jewish and of the general group, we find that the Jewish group constitutes only 13 per cent of the total admissions to and discharges from the psychiatric wards of Bellevue Hospital. This is a surprisingly low percentage in view of the fact that the Jewish group in Greater New York, according to the Bureau of Jewish Social Research, constitutes 28 to 30 per cent of the total population.

Of the 3,012 Jewish patients admitted to the psychiatric wards annually, 53 per cent are committed to state hospitals and 47 per cent are discharged to relatives and friends in the community. These cases discharged into the community are released "in custody" or "on contract," with nothing more than a tentative diagnosis and recommendation. What becomes of these men and women, of these adolescents and children?

In order to find the answer to this question, we decided to develop a program of study and service for this group. We secured from the commissioner of hospitals, Dr. Marcus D. Kogel, and from Dr. Samuel Parker, Director of Psychiatric Services of the City of New York, permission to obtain from Bellevue Hospital the list of Jewish discharges from day to day and also the privilege of abstracting the histories of those cases that we took under care.

Every day we mailed out letters to the patients discharged

* This article is condensed from a full report on the experiments in the mental hygiene field conducted by the Stephen Wise Free Synagogue Social Service Department.

on that day, offering our service. This letter was sent to all patients discharged, with the exception of alcoholics, court cases, and cases under the care of Bellevue social service. We regarded it as most important to mail this letter without delay, in order that no interval might elapse between the time of discharge and the offer of service. If we did not receive a reply to our offer of service within a period of ten days to two weeks, we sent out a second letter.

It is interesting to note that as a result of these offers of service, an average of 70 per cent of the patients who were offered service responded, either by telephone, by letter, or by personal call. An intensive effort to reach a larger percentage resulted in 74 per cent's responding during a period of six months. In other words, we learned that of the 2,313 patients discharged to the community in the course of the year, some 70 per cent, or about 1,600, responded to our offer of service. Of this number we found that about 1,000 accepted the service we offered and about 600 declined it for various reasons that are difficult to classify, because the true reasons were not always given.

In the cases that accepted our service, an initial interview was arranged with one of our social workers. This material and the case were presented to our consulting psychiatrist in weekly sessions. We discovered that of the 1,000 who responded to our offer of service, about 500 per year could be served, and these were taken under care. A plan of treatment was carefully worked out with the psychiatrist in charge and this plan was carried out by the psychiatric social worker in charge of the case. The plan included both cases that required long-term treatment and those that required short-term treatment. No case was closed until we concluded that we had done our utmost to establish the patient and the family upon a level of life as adequate as circumstances would permit.

An intensive study of the needs of cases taken under care revealed that these cases needed the following major forms of service: (1) counseling; (2) psychiatric service; (3) social case-work; (4) employment; (5) convalescent care; (6) institutional care; (7) financial assistance; and (8) a number of minor forms of care such as medical care, nursing care, housekeeping service, temporary residential care especially

for adolescents, recreational care, legal aid, and foster-home care for children.

The conclusions that we reached on the basis of this experiment and the recommendations that we formulated are best expressed in a memorandum submitted to the Federation of Jewish Philanthropies. This memorandum is as follows:

"The latest project that we have conducted in the mental-hygiene field began October 1, 1948. We have now concluded two and a quarter years of the experiment. This project has concerned itself with the Jewish patients discharged from the psychiatric wards of Bellevue Hospital to relatives and friends in the community. The purpose of this experiment has been threefold: (1) to study the needs of this group of patients and their families; (2) to develop a program of service to meet the needs of this group; and (3) to indicate the needs that could not be met because of inadequate resources or the absence of community facilities. As far as we are able to learn, this is the first program of study and service to be instituted for a group of patients discharged from the psychiatric wards to the community. We believe that the conclusions we have reached and the recommendations we are prepared to make will be of interest and assistance not only to the Jewish community, but to the general community as well.

"Our first conclusion is that the patients discharged from the psychiatric wards of Bellevue Hospital to the community, together with their families, constitute a group desperately in need of service, but heretofore unserved adequately by any social agency. This group is growing in numbers as the years pass. A decade ago not more than 20 per cent of the Jewish patients discharged from the psychiatric wards of Bellevue Hospital were discharged to relatives and friends in the community. The rest, about 80 per cent, were committed to state hospitals. At the present time, the percentage of Jewish patients discharged to the community has risen to 47 per cent. This increase has been due in part to the fact that state hospitals are overcrowded and understaffed; and also in part to the fact that psychiatrists in charge of the wards are now of the opinion that a larger percentage of patients can be maintained in the community if they have adequate care and service.

"Our second conclusion is that between 70 per cent and 75 per cent of the Jewish patients discharged from the psychiatric wards of Bellevue Hospital and taken under care can be maintained upon a reasonable level of efficiency if they are given adequate case-work, psychiatric, and other forms of social care. A most important point in this program of service lies in the approach of our agency to patients and their families. Many social agencies believe that they should wait until people apply to them for care. We find, however, that with this group in the mental-hygiene field the wisest plan is to offer service and to do this at the earliest possible moment.

"The reasons for offering service and for encouraging the patients and their families to come to us are clear and convincing. In the first place, in many cases the patients and their families are not aware of their own needs and do not recognize their need for help in achieving improvement and recovery. In the second place, many patients and their families either disguise or deliberately misrepresent their needs. They require patient assistance and skillful interpretation in order to recognize their needs and to accept the service they require. In the third place, many patients and families, for various reasons, personal or social, conceal their needs. This is a difficult group with which to work, for it takes much time and long experience and expert skill to uncover the needs and to aid and encourage patients and families to face their problems frankly and without fear.

"The results of offering service to the patients and their families have been encouraging. In the first six months of our service, only 52 per cent of the patients to whom we offered service responded. In the second year of our service, 68 per cent responded to our letters and offer of service. An intensive follow-up for a period of six months brought the total up to 74 per cent. Another point to emphasize is that these patients and families, when they respond, need guidance and supervision in establishing contact with the agency in the community best able to serve them. Like most people in the community, they know little of the agencies operating in the mental-hygiene field and without counsel and guidance they waste much precious time and money. Only an agency specializing in the mental-hygiene field is acquainted with all

the community resources and is able to give these men and women the direction and assistance they require in the hour of need.

"Our third conclusion is that these patients and their families require in most instances not a short-term, but a long-term period of case-work and psychiatric and social care. When we began this experiment, we thought it would be possible to close cases within a short period—that is, within a period of three months. This we have been able to do with some cases. But the great majority have been in need of sustained and continued service. In other words, we find that cases in the mental-hygiene field are seldom completely cured. In most cases the condition can only be improved, and the patient must be carried forward from month to month under adequate case-work, psychiatric, and social care and supervision and encouragement. In this field of service, we must expect lapses and recurrent episodes, and it is most important that in every case the patient should feel that there is some one and some agency to which he can turn when a recurrent crisis develops. This in itself gives the patient a sense of assurance and support.

"Our fourth conclusion is that if the program of care we have developed is given this group of patients and their families, the community can be saved a tremendous cost both in expenditure and in human suffering. Without this care patients lapse to a lower level of efficiency or relapse into conditions that require commitment to institutions. The average cost of care of the service we have developed is about $100 per patient per year. In the state hospitals the cost of care at present is about $75 per month. If the patient is kept for a year the cost of care is $900. We also find that in addition to the cost of care of the patient in an institution, the community is frequently compelled to cover the cost of care of the family of the patient. If the patient has been a wage-earner or a mother in the household, the community is under the necessity of taking the children under care as well.

"Our fifth conclusion is that there are a number of needs in this group that we have not been able to meet and that cannot be met at the present time because of the limitation of facilities in the community. These needs are chiefly: (1) convalescent care; (2) a work program; (3) a program of

care for children who are discharged from the psychiatric wards of the hospital; (4) a program of care for the adolescent group; and (5) a program of care for the aged and senile.

"1. *Convelescent Care.*—It is very difficult to persuade existing convalescent homes to accept mental-hygiene patients. Only in rare cases and through constant persuasion are we able to secure convalescent care for members of this group. We, therefore, urge that one of the existing convalescent homes be encouraged to equip itself for the convalescent care of mental-hygiene cases. This would mean a staff with special training and experience in mental hygiene, and it would also mean special facilities, including occupational therapy. These patients now suffer exclusion without good reason. They are just as much in need of convalescent care as patients who are recovering from medical or surgical conditions, and they are no more dangerous.

"2. *Work Program.*—It is very difficult, if not impossible, to place the majority of these patients in customary occupations. Most of them are in need of simple, routine forms of work that will not overtax their mental and emotional capacity. The only way in which to provide employment for these patients is through a specially developed work program that would include vocational guidance, vocational training, and vocational placement. Our suggestion is that the Altro Work Shops, which have had thirty years of experience in the tuberculosis field and recently in the cardiac field, be established as the rehabilitation center for the Jewish community. As a rehabilitation center, this agency could develop a work program for mental-hygiene cases as well as for tuberculous and cardiac cases.

"3. *Children Discharged From Psychiatric Wards.*—These children constitute a special problem in the community that no agency is undertaking to solve at the present time. In most cases these children are diagnosed as childhood schizophrenia. They require a special type of service which includes not only case-work and psychiatric care, but also a special educational and social program. The public-school system is not equipped to accept these children. In order to meet their needs, it would be necessary to organize a new and enlarged program of service. Perhaps this could be undertaken by the Jewish

Board of Guardians, which is now developing a more intensive program of care for disturbed children.

"4. *The Adolescent Group.*—There is no agency in the community at the present time that is equipped to serve adequately the adolescent boy and girl who is mentally and emotionally disturbed. This is one of the most urgent needs in community life. We are now convinced, as a result of our experience and findings, that this group of adolescents is in need of intensive, individualized service that includes counseling, psychiatric case-work, and vocational service. We have found that when such services are made available to the adolescent, he or she can be aided to make a reasonable adjustment in social life, and the community can be saved the cost of care through other agencies and in city and state institutions.

"5. *The Senile Group.*—There is a large group of senile cases that cannot be admitted to existing homes for the aged and infirm, and that, on the other hand, are not ill enough to require commitment to state institutions. In fact, they do not need the kind of care that is provided in an institution for the insane. A program of care is needed for this group that lies just between the home for the aged and infirm and the program of the state institution. Until the state is prepared to set aside a pavilion in one of the state hospitals for this group, we urge that one of the homes for the aged and infirm in the Jewish community undertake to develop a program of service for senile cases. This would not be difficult, since some of the homes for the aged and infirm are now taking care of the senile cases that develop in their own institutional population."

SOME FACTORS THAT CONTRIBUTE TO THE CONCEPT OF SELF IN THE CHILD WITH CEREBRAL PALSY

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ONLY a beginning has been made in the study of psychological factors that operate in the field of cerebral palsy. About 10 per cent of the publications listed in the bibliography compiled by Denhoff, Smirnoff, and Holden [1] are devoted to this aspect of the subject. This list could be strengthened by the addition of some of the excellent studies in progress at Syracuse University. The purpose of this paper is to report some of the developing concepts of personality as the individuals themselves reveal them, and to suggest modifying factors and further studies.

Children and young adults with cerebral palsy, and their parents, have made many observations regarding the personality of individuals with this affliction. From such statements, largely made during group counseling, those have been selected that provide some insight into the child's self-concept and its development. The subjective character of the data is recognized; but any study of this theme that omitted material of this nature would be incomplete. Careful selection, however, permits exclusion of statements that could be considered only unsupported interpretations. The parent who believes that her child is just beginning to be aware of the fact that he is different from others, deals in intangibles. She does not readily find words adequate to convey her impressions: "My child does not talk, but I am sure he knows that he is different from others"; "He has not said anything about it, but I am sure he realizes he is different and has his own way of meeting his problem." Inquiry in such instances has revealed that conclusions were based on parents' interpretations

[1] See "Cerebral Palsy," by E. Denhoff, V. N. Smirnoff, and R. H. Holden. *New England Journal of Medicine*, Vol. 245, pp. 728–35, November 8, 1951; pp. 770–77, November 15, 1951.

of facial expressions or some more emphatic overt indication of emotion, such as a temper, tantrum. Neither the evidence of the realization nor any specific description of the mode of adjustment to the condition could be elicited.

Because the condition of one child is so different from that of another and environmental factors vary greatly, a fixed pattern of growing recognition of the significance of the handicap could not be expected. It has been observed, however, that many children, when making their first references to their condition, appear to feel somewhat detached from it. A little girl said to her father, "This arm is no good. I'm going to get a new one." The statement was made with no indication of a more personal involvement than one would feel in speaking about a pair of old gloves: "These are worn out. I had better get a new pair." A typical observation by a boy just entering school was in the form of a question to his mother, "Why do those kids walk funny when they are around me?" If he realized that *he* walked "funny," he said nothing about it. There was some relation to himself, however, since others behaved in this unusual manner only when they "are around me" or "come after me." During his first year in school, this boy became more aware of his involvement in the situation than he had been earlier. His mother first realized this when he asked her, "Why can't I do what other kids do? Why can't I run?"

Children as well as adults are known to use indirect methods of expressing their thoughts. Many children who say very little about their handicaps seem to describe them in their drawings. When one boy drew a man, the head, body, and legs were about as one would expect of a child his age. When that part of the drawing was completed, he began to describe each additional detail verbally. This continued while he drew an arm long enough to reach below the knees, and nine fingers, none of which was attached to a hand. The distance between the two extreme fingers was the same as the length of the arm. Placing the pencil appropriately on the other side of the body, he asked, "How can I give him an arm here? I'll give him just a little one and I won't give him any fingers." The "arm" he drew was the same length as the fingers on the other side. This was an excellent representation of an athetoid with one arm that could not be used and another that could not be well

controlled. The only available explanation was that he had produced a self-concept.

Many children with cerebral palsy realize in a vague way that they are in some measure different from others, but become aware very slowly of the limitations the handicap imposes. They demand the same privileges and the same gifts as others, though they cannot make use of them. A severely handicapped spastic child, with average mentality, did not understand why she could not have skates or a bicycle, though she could not possibly have used either.[1]

Some deny at an early age that there is a handicap, "I am not a cripple," is a statement frequently heard. It may be based on an attitude that the parents have carefully instilled in the child, or it may represent determination to be like others, when the individual has begun to feel the restrictions imposed by spasticity.

It cannot be assumed that every child is aware of the handicap. Some young adults are unable to recall a time when they did not know that they were different from other children. Others, who deviated to a marked degree in speech and gait from their companions, failed to realize it until early adolescence. This condition is true even of children whose mental ability is average or superior. The fact that many people with normal speech do not recognize their own voices when recorded, lends some credence to such reports by young people with cerebral palsy.

Indications of feeling different, ashamed, or guilty may appear at an early age.[2] A report on personality development, based on findings of the Mid-century White House Conference,[3] referred to the developing initiative of the child approximately four or five years of age. He has found that he can go many places and wants to deal in some way with his enlarging environment. The authors direct attention to the belief that a sense of guilt may figure prominently in the child's experience at this age. If he is ill, he may relate his illness to

[1] See "Thematic Apperception Reactions of Crippled Children," by D. C. Broida, C. E. Izard, and W. M. Cruickshank. *Journal of Clinical Psychology*, Vol. 6, pp. 243–48, July, 1950.

[2] See "The Relation of Physical Disability to Fear and Guilt Feelings," by W. M. Cruickshank. *Child Development*, Vol. 22, pp. 291–98, December, 1951.

[3] See *Personality in the Making*, by H. L. Witmer and R. Kotinsky. New York: Harper and Brothers, 1953.

disobedience. A mildly handicapped child in this age range visited a treatment clinic and for the first time saw children with severe degrees of disability. He told his mother that they were "naughty children." Obviously they did not do some of the things the therapists told them to do; to the child, those who failed to obey were "naughty." The importance of the possibility that this concept may develop is obvious to parents who are concerned about the mental health of their children.

Some parents have reported that unintentionally, in their efforts to motivate their handicapped children, they have overemphasized the differences between them and other children and helped to foster thoughts of guilt. One mother recognized that she had done both these things in one sentence which she had used frequently: "Brother does it. Now you be a good boy and try." Another parent, upon hearing this statement, said: "My approach is a little different. I compare my son only to my younger child. I think of some accomplishment for which my handicapped child is about ready, draw attention to the fact that his little brother can't do it, and suggest that he 'show the baby how.'"

Use by the child of his physical limitations to secure attention or gifts is frequently found. Many statements by children could be quoted: "People give me toys because I am a cripple"; "I can roll over, but I like to call my mommy at night"; "I'm going to wet my pants every day. Then she will have to change me"; "I'm making a fuss because I don't want my mommy and daddy to have a good time." Apparently many of these children learn that their handicaps can become assets, and only careful training will avoid an unfortunate personality development.

It is not unusual for children to show their likes or dislikes toward this or that person in accordance with the extent to which one or the other has had to administer discipline. Some parents have observed that their children at times think of therapy in much the same terms as they do of discipline and may react strongly to it. Temper tantrums are frequently reported as developing at the time physical therapy begins. There are reasons why this might be true. If, as numerous reports show, children with cerebral palsy are largely unaware of their handicap, the value of therapies would not be understood by them. Therapies can be a trying, frustrating expe-

rience even when their purpose is understood; they must be much more so when it is not. Many children are bewildered by the inconsistencies between the demands of parents and therapists, or between the demands of the parents themselves. There have been numerous reports of fathers who would promise to give the child his exercises, but would neglect them when the mother was absent, and of mothers who resent the work that therapy involves. The child may look on the more moderate program as a reward or as a reason for favoring the parent who makes the lighter demand. The conflict between home and treatment center appears in the statement: "My mother puts my cane in the closet as soon as I get home. She won't let me walk because it makes her nervous." The result of a lack of unity in the home appears in the remark, "When I grow up, I'm going to live with my daddy. No mother and no babies."

A group of young adults, when considering the problem at length, agreed that the most helpful plan their parents could have adopted would include at least five elements: parents must admit the child's condition to themselves; they should talk about it calmly, unemotionally, when there is occasion to discuss it in the child's presence; they should make it clear to the child, at appropriate times, that his physical condition prevents him from engaging in certain activities; they should provide suitable substitute occupations; and they should face frankly any aspect of the problem, since evasion tends to intensify the child's concern.

Children in the neighborhood frequently impress upon the child with cerebral palsy that he is different, and they do it in a thoughtless or cruel manner. A ten-year-old was accosted on the street by a child of the same age with the words, "You are drunk, kid. Go home and get a hot bath." This is not an unusual experience, though it is more frequently reported by the young adult, who is often accosted, by those who do not know him, as "drunk," "feebleminded," "dizzy," or "a dope fiend."

One of the better known observations regarding the self-concept of an individual with cerebral palsy was made by Dr. Carlson,[1] who said that as adolescence approached, he

[1] See *Born That Way*, by E. R. Carlson. New York: John Day Company, 1941.

became quite aware for the first time that he was different from others. A more comprehensive description by young adults portrays their awakening to the condition as a series of traumatic experiences, each making a more vivid impression than the last. The experience of one girl is typical:

> "When I had reached school age, it was not apparent to me that I was handicapped. I knew there was a difference, but I didn't *feel* very different. It was simply that others went to school and I did not. During the school hours they could not be with me and I missed them. I did notice what appeared to me as an unusual emphasis on walking; my parents never tried to motivate the other children as they did me. They often urged, "If you will only walk, we'll do something nice for you." Or, "If you will walk, we are going to get you a new dress." A close girl friend of mine, who had gone to school, learned to dance and, of course, I could not. When she performed for me, I realized much more than before the way in which I was different. I asked many times if I could go to school, but the only answer I remember was, "Why should you go?" My older sister eventually began to have dates at home and I felt out of place. This was a new idea of the way in which I was different from others. I finally convinced my family that I should be permitted to go to an institution that trained the handicapped. After my condition was studied there, I was told that vocational training was impossible for me, though they softened it a little by saying that I might try the prevocational work. I realized then how badly off I was. When you are first on your own and you find out how helpless you are, then you are aware of what the handicap means. Then you really know."

Professional people must accept a share of the responsibility for the way in which young people realize the meaning of their handicap. Teachers have been mentioned frequently. A young adult said, "Sometimes the teacher herself is embarrassed because she does not know how to handle the situation; sometimes she is attempting to save the child from embarrassment, but she does it in clumsy ways." Some make a point of ignoring the child, so that he never has the opportunity to recite; others call on the handicapped one, but if his speech is slow or difficult, do not permit him to continue. As one youth said, "You never know what to expect. One time you are permitted to recite, another you are not. It probably depends on the mood of the teacher at the time." Some teachers have admitted prejudice against the deviate; others state that they were always uneasy when there was a child with cerebral palsy in the room. Teachers who did not really understand children with cerebral palsy have mistakenly reported them as mentally deficient, socially incompetent, ethically unacceptable.

A change of schools is a very difficult experience, especially when a young person goes from a small grade school where he knows every one to a large high school where most of the pupils are strangers. In the new surroundings the individual who is handicapped expects to participate in activities as he did in the smaller school: "You want so much to do the things others do, but you soon learn you won't be invited. You knew in the seventh and eighth grade that you were different, but that was a very vague experience. It was worse for me, I suppose, because I had a principal who did not like the handicapped. It was in high school that the realization of what the handicap meant really hit me. When boys dated others and did not date me, I realized most vividly how different I must be."

Some of the handicapped think that physicians, through the terms they use, help young people to develop mistaken ideas of themselves. One girl reported: "My doctor said that I have *good* hands. Actually my hands are too slow for typing and too stiff to develop any artistic talent I might have. In the doctor's technical language, my hands may be 'good,' but as I understand the word and for practical purposes, they are not."

If parent and child had to adjust only to the physical handicap, it would be serious enough; but the child's personality and what he thinks of himself are affected by his mental condition, and what he and others think it is. As one mother said, "The physical handicap is bad enough, but it is the mental retardation that has me panicky."

Up to the present, few realistic reports have been published on the mental level of the child with cerebral palsy. A statement made by one father appears to have some application to professional people as well: "In thinking of mental capacity, some parents see what they hope is true, rather than the actual condition." Several recent psychological studies involving from 300 to 1,000 children are in agreement on two points—that approximately 50 per cent of children with cerebral palsy are mentally deficient, and that evidence is lacking to support the belief that any one medical classification shows marked intellectual superiority over the average for the spastic group. The results of efforts to teach children with cerebral

palsy incline educatiors to agree with these two current points of view.

One study revealed that, because of their mental levels, almost 30 per cent of the children with cerebral palsy are not acceptable in the public schools as now organized, nor would they profit to the extent that boards of education expect if home teachers were provided. Approximately the same percentage would be able to reach high school; many of them graduate and some profit by college training. The remainder, just over 40 per cent, would be found scattered from the first to the eighth grade when they had completed all the school work of which they were capable. This report is not welcome; but it is based on the largest group of individuals with cerebral palsy that has yet been studied.

A constructive point of view expressed by one mother could well be adopted both by parents and by professional people: "As a parent I am interested neither in mental age nor intelligence quotient. I want to know what my child is able to do now, and what training he should have now." Classification under either of the two concepts, mental age or intelligence quotient, may do an injustice to any child, but is much more apt to do so in the case of those who have cerebral palsy. The important matter for present consideration is that individuals with cerebral palsy have been categorized as a group and have suffered in personality development as a consequence. They should be accepted as individuals and given every possible opportunity for development.

Young adults have expressed resentment that, in large measure, people with cerebral palsy have come to be known by what they lack, rather than by the capacities they possess. "You cannot play with other children; you cannot go to school; you cannot marry; you cannot support yourself." Undue optimism is apt to damage personality development as much as the negative approach. The parent who said, "I have always taught my child to believe that there is nothing wrong with him," was laying a foundation for serious conflict.

Somewhere between the extremes the individual as he is may be found. Intellectually, he may be anywhere from the lowest to the highest level. There is no necessary correspondence between the extent of the motor handicap and the

mental capacity. It is true that the more severe the physical limitation, the more likely one is to be mentally handicapped; yet in any individual case, the opposite may be true. The most detailed examination should be made in order to determine the nature and the extent of the mental handicap, if one exists; but at least as much time and effort should be devoted to discovery of the individual's capacities, and the reasons, other than the physical disability, why these potential assets are not more fully expressed.

The foregoing has revealed some measure of progression in the concepts of the cerebral palsied, from vague recognition that people are assuming a certain attitude directed only toward them, to a realization that this attitude is related to their peculiar physical condition. The significance of the reactions they observe and the nature of their disabilities become increasingly clear.

A summary of the relationship between physical development and personality and one feature of the environment should contribute to an understanding of the developing self-concept:

Reference to the Mid-century White House Conference findings reveals emphasis on five outstanding characteristics of the development of children from birth through early adolescence. Within the first year, the child finds that he can depend on the people about him to supply his needs and on his body to respond in certain ways that he may choose. By the time he is three, his dependable body has in some measure given him freedom from others, so that he can do more things because he wants to do them. With increasing frequency, between the years of four and five, he initiates action; he dresses himself, goes to the homes of his playmates, explores other places without the constant supervision of earlier days. During the next six or seven years, he discovers many things of real value that he wants to do, some that he is required to do. Childhood activities merge into those of adolescence; there is a new sense of independence as the child seeks to learn his place as an individual who is about to assume certain new responsibilities and privileges, and to prepare for others of constantly increasing personal and social significance.

Most children with cerebral palsy are delayed in each of

these periods of development, the seriousness of the retardation depending on the nature and extent of the physical and mental damage. There is less chance that in their first year they will learn to depend on their muscles to react as they desire. The handicaps, often multiple, continue to retard or to alter their development at every stage. These children cannot care for their personal needs; nor can they explore or socialize with the facility and frequency of others. Initiative and a sense of self-sufficiency evolve with great difficulty or not at all. If the cerebral palsied get to school and meet no other frustrating experience, they find that they are older than their classmates and suspected of lacking intelligence. They are unable to participate in most activities through which school children establish status among their companions. If they could return to a home in which there was acceptance and understanding, life might be more tolerable, but many of them find the home no such haven.

At the beginning of a counseling experience, parents have frequently expressed a wish to discuss some subject that had no particular emotional significance to them and later have progressed to much more profound problems. Individuals have reported progress from almost complete frustration to insight and excellent adjustment to the problems involved in having a child with cerebral palsy. Such a progression is represented in the following series of selected quotations:

> "It should be possible to let these children die, or cause their death."
>
> "My husband would not allow any of us to mention the handicap."
>
> "I have children and I raise them because it is God's will. I have no feeling about it and no desire for them."
>
> "I expect the same of the crippled child as of any other. I make no allowances and accept no excuses. I rule this house and I rule it with an iron hand."
>
> "Feeling guilty gets to be a part of everything we think. We just take it as something that we have to bear and can do nothing about."
>
> "Having a cerebral-palsied child has caused much friction in our little family. Each of us blames the other for it, but neither one comes out with it directly."
>
> "I got so I couldn't lift my child; he was getting heavier and had long braces besides. Now I realize it was not his weight; it was non-acceptance. It's the way I feel. I'm resentful and I just want to throw off the responsibility."

"You are not guilty of anything just because you have a cerebral-palsied child."

"Some become artists, some missionaries. My life work is to teach my child to do and be all that is possible for him."

Attitudes such as these must have a profound effect on the children. Parents know it; and children are often fully alert to the implications of what is said. The first of the following statements is by a child; it may be compared to some already quoted. The others are by parents:

"Nobody can do anything in my family because of my handicap. It costs so much for my therapy that my parents can't have a vacation."

"What does it do to a child when he knows something is being withheld from him either by very obviously deferring an explanation, using words he cannot understand, or spelling out words, so he will not know what is said?"

"When I am feeling bitter, he recognizes my frame of mind and reacts against it."

"If I do a lot of things for my child, he sees through it. He knows how I really feel."

A careful classification, recognizing the implications of the context of 250 quotations that showed some type of parental attitude toward children with cerebral palsy, revealed that 74 per cent were negative in nature. They ranged from mild forms of rejection to frank expression of death wishes. Obviously parents availed themselves of the counseling service because they had problems to discuss. The harsh statements they made need not reflect constant tensions in the home. Yet the effect on personality development of even the more moderate expressions of rejection should not be underestimated.

Further study of home environment and the possibility of modifying it through counseling is now being undertaken. Bice and Bartelme are developing an instrument for the purpose of measuring changes in attitudes of parents during group-counseling experiences.[1] Since this scale is made up entirely of statements by parents, much of the emotional atmosphere of the home is revealed. A second part of the study is designed to measure the effects of parental attitudes on the personality development of children, thus supplementing some of the data presented here.

[1] See *Attitudes of Parents of Exceptional Children*, by H. V. Bice and P. Bartelme. In preparation.

Counseling, as it has been organized and described,[1] can contribute significantly to the total effort to solve problems related to cerebral palsy. For the good both of parent and of child, it offers a method of understanding personality development; a description of conditions pertinent to good mental health; and a technique for assisting in healthy personality development. By itself it is too subjective, just as clinical judgments are; but it provides a good background for a more objective type of study.

[1] See *Group Counseling with Mothers of the Cerebral Palsied*, by H. V. Bice (Chicago: National Society for Crippled Children and Adults, 1952). See also "Group Counseling with Parents of the Cerebral Palsied," by H. V. Bice, in *Psychological Problems of Cerebral Palsy* (Chicago: National Society for Crippled Children and Adults, 1952) and "Group Counseling with Mothers of Children with Cerebral Palsy," by H. V. Bice and M. G. D. Holden. *Journal of Social Casework*, Vol. 30, pp. 104–09, March, 1949.

BOOK REVIEWS

SEXUAL BEHAVIOR IN THE HUMAN FEMALE. By Alfred Kinsey, Wardwell Pomeroy, Clyde Martin, and Paul Gebhard. Philadelphia and London: W. B. Saunders Company, 1953. 842 p.

The readers of MENTAL HYGIENE are probably interested in knowing what contribution, if any, the Kinsey study makes to human happiness. This is a large order, which the reviewer can hope to fill only in part.

The problem of sexual adjustment may be viewed from three perspectives—the biological, the psychological, and the social. Mr. Kinsey is a biologist, and his contribution is mainly in the area of the biology of sex. He is concerned primarily with man, the animal, and he appears to have a great deal of sympathy for Herbert Spencer's dictum that concern for good health is the first requirement of a sound social system.

Kinsey includes a great deal of material on the physiology of sex and reviews carefully the data on the sex behavior of mammals. Animals in good health behave thus and so. Where conditions are favorable, they engage in heterosexual intercourse which, therefore, becomes the normal outlet for direct sexual expression. If conditions are not favorable, the lower animals may masturbate or engage in homosexual intercourse or both. So, implies Kinsey, man, the animal, should be more tolerant of these forms of sexual expression, which are considered deviant in our society and, therefore, condemned. Moreover, Kinsey's data show that these outlets are actually not deviant, if statistics are a criterion of normality; nearly all young men and many females masturbate more or less. Homosexuality is not uncommon. We should not be so harsh in our treatment of homosexuals, thinks Kinsey.

Kinsey's contribution on the biological side is impressive. His statement regarding the physiology of the sexual function of human beings is probably the most complete and authoritative that has appeared in print. His data on the sexual outlets are the most comprehensive available and give us new knowledge that is invaluable. For instance, of great significance is Kinsey's finding that the peak of sexual activity in males is generally reached in adolescence, whereas the peak in females occurs in the late twenties.

Because Kinsey is authoritative as a biologist, it does not follow that he is right as a psychologist or a sociologist. Let us pursue the biological analogy a bit further. A healthy male animal, functioning in a normal biological manner, may copulate with his own daughter. He knows nothing of incest taboos. On the contrary, there is not a single known instance of a human society without taboos against incest,

although the definition of incest varies somewhat in different societies. The incest taboo is a major social invention made by man primarily for the purpose of preserving order and discipline in the family; and it is difficult to see how authority patterns and efficient division of labor can be maintained without it. Is man, the animal, to ignore the incest taboo?

On the psychological front also, the data are inadequate, since Kinsey saw only reports of sexual outlets without reports of the causes and meaning of these modes of expression. Kinsey is interested in orgasms for women because they are correlated with marital happiness, though this knowledge is obtained from other studies, like those by Terman, and is not supplied by Kinsey. Does it follow from this that the accent should be on orgasms? Perhaps married women have orgasms because they are happily married, and are not happily married because they have orgasms. It is possible, of course, for married women to have orgasms without being happily married.

In any case, mature men and women are primarily concerned with promoting each other's welfare; the emphasis is on the psychological processes of empathy and affection, and the husband's concern for the full sexual expression of his marital partner is a manifestation of his regard for his wife's personality and welfare. To focus on the biological means may defeat the psychological ends. It is better to focus on the psychological ends and utilize the biological means to help achieve the ends of marital respect and love.

Kinsey's study does not concern itself with meanings. It is not proper to criticize a book for what it does not undertake to do, and yet the psychologists and psychoanalysts must be very unhappy not to find in Kinsey's vast inventory of the sex life any explanation in psychological or social terms. Wide variations in behavior are reported, but we are at a loss to account for them.

The basic question remains: What is the proper adjustment of group life to man, the animal? A culture that serves man efficiently is one compatible with his biological nature. But the biological needs of man are by themselves insufficient criteria for adequate social norms. Kinsey has given us a monumental study of the biological aspects of human sexuality, but he has not solved the problem of the proper adjustment of man and culture in the sexual order.

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The American Family. By Ruth Shonle Cavan. New York: Thomas Y. Crowell Company, 1953. 658 p.

The extended interest in marriage and family-life education in recent years has brought about considerable specialization in teaching

and research, on the one hand, and a broadening, interdisciplinary point of view, on the other. This trend is reminiscent of the changing sociological trends in the family itself, and, at the same time, it bespeaks the importance of so basic and intimate a relationship for our future society. That the coming generation of married folk may understand the forces that have shaped the American family and that they may be better equipped to meet their and society's needs, Cavan has chosen the interdisciplinary outlook and has combined the sociological with a practical point of view to give us an excellent textbook for college students.

Utilizing the same sociological approach and something of the same organizational pattern that made her earlier text, *The Family*, so successful, Cavan has strengthened her earlier position by extensive use of authentic and current empirical data. Research findings from all related fields bearing upon the issues appropriate to her theme are skillfully woven into her analysis.

The sociologist will particularly appreciate the chapters on "Social Configurations of the American Family," in which the author treats upper-, middle-, and lower-class families, ethnic families, social mobility, and cross-cultural marriages. The psychologist and mental hygienist will find her interpretations of personality, love, sex, and marital and familial problems perhaps overly simplified and, therefore, of more practical than theoretical significance. But this may prove, for the student at least, a definite advantage over some of our more theoretically oriented texts.

The book is well organized. Its objectives are clearly stated and well achieved. Students and teachers will find it readable. And no one can read or study this volume without having a clearer understanding of the issues facing the American family to-day—the changes that have taken place in the structure and functions of the family; the forces effecting these changes; the interrelations of the family and society, particularly in terms of the class system, social mobility, and group tensions; and the complex forces involved in the cycle of family life from the period of adolescence through marriage into old age.

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PARENT AND CHILD. By James H. S. Bossard. Philadelphia: University of Pennsylvania Press, 1953. 308 p.

It is the purpose of this book to determine the significance of a variety of familial influences upon child development. To this end the author studies such situational factors as immediate family backgrounds, the larger kinship group, remarriage of widowed or divorced

parents, disharmony in class origin of parents, paternal occupation, position of the family in the social-class structure, wide disparity in ages of parents and children, the rôle of domestic-animal pets, guests in the home and child visiting away from home, and "the interactive space index" that the author has developed for measuring the interpersonal relationships within the family group.

This latter concept indicates the distintively sociological and cultural level that characterizes the discussion throughout. The commonly used "number of persons per room" is adequate only for measuring the physical and physiological aspects of family living. It gives little indication of the social and cultural pressures that nearness in physical space places upon the family members in their relations with one another. For the physical and physiological demands upon space increase as the number of persons involved, but the sociological and cultural demands increase as the number of interpersonal relations between them. The former is a mere matter of arithmetical progression, while the latter is a matter of the progression of triangular numbers.

But like W. I. Thomas and others whose insights into the subtler nuances of behavior have been enduring and profound, the author realizes that such statistical indices, however refined, are "nothing more than symptoms of unknown causal processes," of underlying stresses, frustrations, and adaptations which the author seeks to discover by other means. It is his purpose in each case to penetrate beneath the array of people and things that constitute the concrete and tangible life-setting of the child to the inner qualitative world of meanings, attitudes, and relationships that constitute it psychologically and culturally. Questionnaires and schedules suffice to secure the former type of background data which can be spatially ordered and quantitatively expressed; but for the latter, reliance must be placed upon relatively free associational writing for the more literary, and upon nondirective interviews for those whose freest mode of expression is conversational.

These materials show that physical settings are sociologically important to the child only as they structure his behavior, and adults only as they meet his needs. Consequently, the larger kinship group plays a much more important rôle in child development than many recent studies, with their tendency to concentrate too narrowly upon the immediate family as a somewhat arbitrarily isolable influence in the child's development, have supposed. This dominance of the immediate family, the author thinks, is true of only a minority of family backgrounds. From the child's point of view, the important family group is not the "procreative unit" of father, mother, and siblings, but the "interacting family" of those who meet his needs. "They are needs which grow out of experience in living: the extent

to which they are met registers the family member's importance in the development of the child. This does not mean that surrogate parents can meet all the needs of children. There are fundamental longings, of belongingness, for example, that only a parent can give, but there are many other needs that can be met only by other persons. We must not sell short the rôle of non-parent family members." Kinship ties are neither as vague nor as weak as they are often assumed to have become.

Only as we pass through the stages of development in which our parents were when we first knew them, do we cease to think of them as purveyors to our needs, and understand them as persons like ourselves, with lives and problems of their own. Their influence upon us then reaches its highest point. As "we remember how they did thus and so, we decide perhaps that they were good and wise parents after all, to be emulated in turn; or that they were weak, or unjust, or unreasonable, whose example is now to be eschewed. But even here we may understand a little more clearly the how and the why of the weakness or unfairness."

The foregoing quotations are representative of the clear style and balanced judgment of the book. These qualities should commend it to parents, family counselors, child-welfare workers, teachers, and similar consumers of research.

Its value to the clinician will consist in the research findings, based largely on non-clinical material, with which it provides him for comparative purposes, while the researcher will find helpful the summaries of generally accepted fact and theory on each topic presented by the author as introductory to his own findings, which he modestly regards an "pilot studies," suggestive of page after page of hypotheses for further testing and questions for further inquiry.

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BRIGHT CHILDREN. A GUIDE FOR PARENTS. By Norma E. Cutts and Nicholas Moseley. New York: G. P. Putnam's, 1952. 238 p.

This book, as the title would imply, is a practical book. It is written to help the parents of bright children, and it deals with the special problems that such children may present from infancy through college age. By "bright children," the authors mean the upper 10 per cent of children in intellectual capacity, those who would be classified by psychologists as superior or very superior, and those who are likely to profit most from education and who have the best chance of becoming leaders in later life.

There are fifteen chapters in the book, covering such subjects as

mental hygiene, first steps in school, difficulties over marks and homework, home supplement, public as compared with private schools, choosing a vocation, going to college, and the parents' responsibility. Throughout the text and in a short list at the end, pertinent titles are given for further reading.

The authors based their discussions on information gained not only from the literature, but from answers to questionnaires and from personal interviews with bright children and their parents. One particularly rich source of material was a set of diaries, kept by a mother of three bright children. These included the actual sayings of the children as well as accounts of their doings. Throughout the book there are frequent quotations from the recorded remarks of bright youngsters or their parents. These give authenticity to theoretical discussions and provide human interest for the reader.

The whole book is delightfully and sympathetically written both for the parents and the bright young people themselves. In fact, older boys and girls might do well to read and study the chapters on "Looking toward a Vocation" and "On Going to College." Reasons are given for and against making an early decision as to a vocation, and ways are suggested for finding a suitable solution to the problem of choosing a vocation for each individual.

Throughout the book, the authors maintain an unbiased attitude. They present the advantages and disadvantages of public and private schools for bright children, and they list some important questions for parents to ask of themselves and the schools when trying to decide where to send their children for the most suitable education. The best course of action to take must necessarily depend upon the particular child and the particular school under consideration.

In the chapter on "Discipline," the problem of jealousy is discussed and is given the usual interpretation found in books on child psychology. This is that the jealous child feels he has lost affection previously shown to him or due to be expressed toward him. The present reviewer of the book would want to add an alternative explanation of jealous behavior. A warm-hearted and yet jealous child might feel frustrated by the reduced opportunity or total lack of opportunity to express this affection toward his parents. Whichever explanation is held to be true, the practical suggestions given for parental action to minimize undesirable feelings and manifestations of jealousy would be likely to succeed.

One refreshing quality in the book is that it is straightforward and not as sloppily sentimental as some books written primarily for parents. The authors discuss problems in a clear and broad-minded fashion and they refrain from giving bold and specific advice. Their aim appears to be basically to help parents to help themselves. The only

strong recommendation is made in the last chapter, which urges bright children to go to college. The authors consider college to be worth the work on the child's part and the sacrifice involved on the part of the parents. Useful information is given regarding the kinds of scholarship available and some college-entrance requirements. Further sources of information are mentioned.

All in all, this is the sort of book that is likely to be welcomed by parents, teachers, and any one else who has charge of bright children, and it is one that they will enjoy reading.

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CHILDREN OF DIVORCE. By J. Louise Despert, M.D. Garden City, New York: Doubleday and Company, 1953. 282 p.

This is a much needed book, written not only with essential insight, but with fine objectivity and a constructive optimism. It will prove invaluable to parents and counselors who are trying to guide children through the emotional hazards of divorce with a minimum of damage.

Dr. Despert points out that "divorce is not disaster"—that if it is wisely handled, children may come through it with as good a chance for constructive, happy lives as children who have not been through it. She emphasizes that it is the emotional divorce—the tension and conflict, the breakdown of communication—that precedes legal divorce that is damaging to children, and that is found among many couples who never get to the divorce court. She came to this conclusion upon noting that there were a smaller proportion of children from divorced homes among the disturbed children who came to her as patients than is found in the general population! Yet in every case the parents of these disturbed children were emotionally divorced. She emphasizes, therefore, that as soon as parents are aware of deep unhappiness in their relationship with each other, the children should be helped, but that often the parents' own struggles blind them to this fact.

She gives vivid illustrations from her own case histories as to how parental conflicts look to children, the feelings of guilt and anxiety that many develop. She gives also helpful suggestions as to the kinds of explanation and loving that will reduce their fears and sustain them through the break and the subsequent reorganization. From her wide experience, she makes the reassuring observation that with enough good help, even many of the children to whom such help comes late can look forward to a bright future. She feels that in addition to efforts made to save the reality of the marriage and, failing that, to help each partner make needed readjustments, we must give our best

thought and help to the children of divorce, since their lives go farthest into the future.

No parent who has struggled through marital unhappiness, whether or not it has ended in divorce, should miss the great help to be gained from the sobering, but stabilizing and encouraging wisdom on every page of this book. Teachers, counselors, and others who work with such parents will also find in it a highly valuable aid.

KATHARINE WHITESIDE-TAYLOR

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FILMS IN PSYCHIATRY, PSYCHOLOGY, AND MENTAL HEALTH. By Adolf Nichtenhauser, M.D., Marie L. Coleman, and David S. Ruhe, M.D. New York: Health Education Council, 1953. 269 p.

With the publication of this book, workers in mental disease and mental health have now an excellent tool, guide, and reference source for evaluating films in their field. They have in addition meaningful and significant comments and information about this topic.

The study considers both technical and popular films, and consequently it will be helpful to a large audience of readers.

The major part of the book consists of critical reviews of selected motion pictures in the psychological fields. However, its four introductory chapters are also of considerable importance. They provide perspective and background for the reviews by discussing various aspects of current mental-health films, including their history, the relations between their psychiatric content and motion-picture presentation, and their use in professional training and public education.

These preliminary chapters should be very valuable to persons concerned with the use of the films. For example, they mention the careful preparation required by the authors for reviewing the films and analyzing them. Comments are also made regarding the limitations of the study in that it was not possible to examine thoroughly, through first-hand experience, the effectiveness of technical films under actual undergraduate, classroom conditions, and the use of mental-health films with groups of lay persons.

Other high lights of this section include astute observations regarding the production of motion pictures dealing with topics involving intra- and interpersonal behavior. The authors find that in technical films the intimate portrayals by the individuals themselves in the films are more convincing and appealing than the enactment of their rôles and behavior by others. This is true even if the subject is less skilled than the professional or substitute actor.

There are also valid hints and suggestions for precautions to be taken by those responsible for preparing films with dynamic psy-

chological content. Some of these observations seem to be obvious, but the authors are able to document the instances in which procedures have demonstrated either awareness of or insensitivity to these details.

This part of the volume, in addition, discusses the appropriate use of motion pictures in mental-health programs, and stresses the need for careful discussion and orderly presentation of them. The four chapters of this portion of the book represent only a small part of its contents, yet they are worth while and merit close examination.

The main body of the publication is devoted to critical and comprehensive reviews of fifty-one films dealing with psychiatric, psychological, and mental-health subjects. Each motion picture is examined in terms of five conditions. It is reviewed for "content," which includes study of its purpose and objectives, subject matter, and technical content. The film style (whether case histories, reënactments, or dramatizations are used) and technical skill (camera work, direction, and acting) are appraised under the heading "Presentation." "Effectiveness" is the third factor, and this includes, "What can be learned from the film," "Who can learn from it," and "How well can one learn from it."

The fourth basis for analysis investigates the film's "utility," or suggestions for use, suitable audiences, and recommended study guides. "Production and distribution," with complete information regarding rental and purchase data, is the final item reviewed.

Study of this publication reveals the thorough and comprehensive nature of the reviews. Consequently they can be of immeasurable value to educators in technical and lay areas of the mental-health field, to workers in these professions, and to program consultants and planners.

For the individual who may work specifically with lay persons, the review section is particularly important. The reviewers have commented on those films that require emphases because of weakness in their content or in the presentation of a technical concept. If the message that the film points out is not self-explanatory, the authors indicate this and suggest the need for a careful discussion period and clarification of the overlooked principle.

This book deserves serious consideration and perusal by persons functioning in the fields that it surveys, and it is an important contribution to them.

EDWARD LINZER

The National Association for Mental Health

OUT OF STEP. By Jçseph Trenaman. New York: Philosophical Library, 1952. 223 p.

The mission of an army in wartime is the destruction of an enemy. An army and a nation at war mobilize their resources for this single purpose. Conservation of resources, especially limited ones, is essential. Man power is a primary resource, usually limited, and, therefore, in recent wars an object of considerable emphasis. Especially with the complexity of modern warfare and the tremendous industrial man power needed to support an army at war, the man power requirements of the military must be reconciled with continuous needs. The maximum utilization of men in the armed forces means not only the classification and utilization of highest skills, but also the necessity that every effort be made to adapt soldiers who are having difficulty in the transition from civilian to military environment.

This volume is an attempt to analyze such an experience in the special training units formed by the British army in September 1941, when they began to feel the pinch in man power. They were finding a considerable number of young soldiers who were not adapting to the military requirements of behavior imposed upon them. These young soldiers were essentially disciplinary problems, to distinguish them from the special training units that the U. S. Army developed to help soldiers who were essentially illiterate or non-English-speaking. The closest American counterpart with which this reviewer is familiar would have been the disciplinary barracks, which attempted the rehabilitation of soldiers sentenced to terms for violation of the various Articles of War.

The author's approach to the reclamation of these young soldiers (under twenty-one years of age) appears to have been essentially educational or reëducational. He was in charge of this training, or what he calls "special" training, at one of these units, and the content of the volume is the result of his experience. The directive that enacted these units called for "careful individual treatment," which the author interpreted as offering "the widest opportunities for experiment."

There is a description of the program which, in the table of contents, is titled "Methods of Training," but which appears as "Methods of Treatment" in the body of the content. The author plaintively suggests that "a resident psychologist could have contributed much," and explains that "there was only a visiting psychiatrist available to whom difficult cases were referred for an interview of half an hour or so" for evaluation and recommendation, "but, as some army psychiatrists would readily acknowledge, it was not possible to gain a man's full confidence in one interview." And from this limited clinical

service, the author notes: "Seldom was any practical suggestion offered for treating or training a man who was to stay at the Special Training Unit." The chapter on "Methods of Treatment" offers interesting content on a group approach to delinquent behavior that, while not uniquely original, confirms some well-established theory and practice of group-work agencies. The results achieved are modestly stated in the following chapter.

The main body of the work—an analysis of the men, their conflict with the army, their civilian background, and the conclusions—are parts II through V of the book. The author saw a study of delinquency as a potential in the content to which he was being exposed. He hit upon a clever educational method of securing the participation of the men in a questionnaire, and the large proportion of his statistical material apparently derives from this method.

There is considerable reference to sociological and psychological studies in the attempt to establish correlations with the group under study. These appear throughout the test. They cover such items as height and weight, disease and disorders, intelligence (from army group tests), educational achievement, mechanical aptitude, and so on. The author indicates that a further study would be necessary "to explore the many emotional conditions found amongst a delinquent population," and says that his inquiry "makes no attempt to trespass on ground that properly belongs to the field of technical psychology." However, the author continues, "some empirical classification of attitudes had to be made."

At this point the content has less clarity except where the stories of the men are recorded and would be of interest to clinicians. This interest and limitation would apply to the remainder of the body of data under analysis; but the opportunity for reading an account of environmental factors as seen in a comparative culture will be of some reward. The value of the book is enhanced by the unusual circumstances and the setting in which the data were compiled.

While one could be critical of the conception and methodology of the study, even as it stands there is much to be learned from the book, although the conclusions will be of limited value to advanced workers in the field. We are indebted to the author and to his associates who, in a situation of what must have been considerable pressure and handicap, attempted to develop and record their material in a systematic manner.

HARRY L. FREEDMAN

Psychiatric Service, Clinton Prison,
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PATHS OF LONELINESS. By Margaret Mary Wood. New York: Columbia University Press, 1953. 250 p.

Here is a book that has grown through a number of years of reading, thought, and introspection. The author has brought together a wealth of references, many quite apt and revealing, that bear upon the main theme of the isolation of the individual in modern society, beginning with Matthew Arnold's musings on the death of a canary to Thomas Carlyle's identification of "emotional tomfoolery."

Underlying the entire volume is a keen appreciation of the tragic problem of the individual in a society that tends to increase his loneliness even as it multiplies his contacts. The rôle of various factors is clearly recognized. Changes in the family, occupational requirements, the loneliness of high place, the mark of the underworld, the physical deviate, the lust to wander, the insulation of egotism, the recourse to authoritarianism, the lure of superiority—all of these are clarified and emphasized, with selected literary, personal, and scientific observations.

To the reviewer, who has approached the problem of the modern isolate in terms of certain basic social processes, the failure to emphasize the shift from primary to secondary group living is disappointing. On the other hand, one welcomes the tapping of other than conventional sociological sources, for it seems obvious that the comments of literary folk, jurists, biographers, and the like are not without insight, too, into life situations.

This book is written in a delightful style, which one hopes the esoteric will forgive. The problem it pleads is as significant as it tends to be obscured. The bibliography is suggestive for its comprehensiveness and valuable for its completeness. Considered as a whole, here is a volume that should find its place on the shelf of the student of the behavior of the contemporary individual, as he struggles under the impact of a world that to many is cruel and meaningless, and to all is a challenge.

JAMES H. S. BOSSARD

University of Pennsylvania

THE GREAT ENTERPRISE. By H. A. Overstreet. New York: W. W. Norton Company, 1952. 332 p.

This professor of philosophy at the City College of New York, now retired, has over many years rendered a notable service by explaining modern psychology to lay persons and so helping them to a wiser management of their lives. Whether the field is public health, or electronics, or social science, there is a great need for the writer who can mediate between the specialized, technical expert and the

plain people for whose support the expert is so often obliged to plead. In a democracy, such mediation takes on major importance. Dr. Overstreet helped here by offering his *Mature Mind* some two years ago. The book aided many individuals to a wholesome examination of their own ways of responding to tension and encouraged them to observe how a genuine maturity would require them to behave.

Because the book limited itself to this problem of the individual life, the present volume looks at the matter from the standpoint of maturing our social culture. Without being a determinist, Dr. Overstreet is aware of the influence exerted on this or that life by the impact of such social agencies as homes, schools, churches, newspapers, occupations, and local and world-wide political affairs. Making all these more conducive to liberating rather than blocking the individual's powers of maturation is to him the great enterprise, calling to-day for more people of intelligent good spirit. Our biggest problem is "to create those relationships of confidence and good will that promote our living together as human beings."

Where the older medical practice was content in the main to regard mental disease entirely as something inside the patient himself, to-day's doctors are beginning to see that they must also study the individual in his relationships with the world around him—that is, in his interplay not only with other individuals, but with institutions, cultures, climates of opinion, social expectations. Some behavior of juvenile delinquents, for example, goes back in large degree to a more or less conscious feeling that the adult world is hostile to them. Rebellion ceases to be an important want when there is "no longer an ego-defending function for it to serve." False, and therefore hurtful, images of the self are tied in with false images of others, as in Nazism and similar "holy hates." Any culture that puts a premium on outsmarting others rather than on achieving success through fellowship, voluntary services to the community, creativeness, is more likely to breed unhealthy personalities.

To-day's life of world-wide tension and anxiety the author regards as especially conducive to that stormy climate of immaturity in which people are more apt to hate, hit, steal, smash, kill, and no less to regress to childish dependency and irreponsibility. "The maturer habit of searching out the nature of things and doing only what our disciplined conclusions bid us do," is now more urgently required than ever. Every educational influence is needed to replace the "it's-nothing-else-but" view of causality by the sounder attitude which asks, "What else may be behind this unfortunate business?" Multicausal ways of thinking can be listed high among the gains already to the credit of modern science.

How, then, can we create a society in which friendship and love

will get more chance to flower? What can we do to increase (as, for example, the best of modern schooling tries to do) the experiences more likely to widen and deepen areas of affection? How can we awaken intelligent concern for such living? What part will a forward-looking religion play in this enterprise? Are we sufficiently aware how superior democracy is to dictatorship in providing, for example, elections rather than murderous battles as outlets for hostility? And are we as attentive to the positive blessings of democratic living as we are to the hateful features of communism?

> "Perhaps the greatest of all the psychological hazards the individual faces to-day is loss of faith in the democratic process—which is, in effect, a loss of faith in man himself. In the midst of the endless antagonisms of people, and in view of their apparent inability to understand one another and to coöperate with one another for a common welfare, he may gradually, or with sudden despair, come to believe that the democratic processes will not work. Human beings, apparently, are not up to them. Hence, he may be led reluctantly to agree, for the time being, to the surrender of basic human rights—freedom of individual opinion; freedom to speak one's mind; freedom to criticize those in authority; freedom to associate with others; freedom to learn and to teach; freedom to be regarded as innocent until legally proved guilty. He may be led to agree to the surrender of these at the very time when they are most needed to fulfill our democratic rôle in the world."

These concerns raise large questions; and the author of *The Great Enterprise* does not pretend to know precisely what will answer every one in detail at this moment. He is awake to the fact that when reason proves powerless, unreason takes over, as it is doing right now in more than one locality here in America. But he does not lose hope. The closed worlds in which too much life to-day is lived are the creations of men's neglect and folly. The more open worlds, those in which "the great dependabilities of human relations" are operative, need first of all people who are awake to the need and will do their part to help meet it. Among the signs that more men and women seem to be so ready, the author lists our growing awareness of the menace in modern warfare, our deeper understanding of sub-surface motivation, our realization that the more advantaged are themselves imperiled by the sub-standard of living of other millions on our globe, our increasing demand for some measure of effective world law, our approaches to sounder ways of educating both young and old. He may be mistaken; but so likewise may the utter pessimists. At the least there are these things that experts and plain people both can try to do:

> "Look for ways in which artificial barriers between man and man can be removed; ways in which hate-breeding misunderstandings can be cleared up; ways in which experience conducive to the growth of affection can be created and widely shared; ways in which people can become involved in concerns that carry them beyond self-interest into humanity-

interest. Such encouraging of love and diminishing of hate becomes the main life task. It becomes the most important thing for the spirit of man to care about. And once a man is deeply possessed by the health and joy of such caring, it would scarcely occur to him to ask how he, as a special and separate individual, can best assure his own special and separate salvation."

HENRY NEUMANN

Brooklyn Ethical Culture Society

ANNUAL REVIEW OF PSYCHOLOGY. Vol. 3. Edited by C. P. Stone and D. W. Taylor. Stanford, California: Annual Reviews Inc., 1952. 462 p.

The major objective of these annual review volumes is to take stock of new and important contributions to psychology from all the laboratories of the world. This year, for the first time, the services of eminent foreign psychologists have been secured—Elmgren of Sweden, Eysenck of England, and Piaget of France—with additional European contributors assured by the editors for future volumes. This emphasis on balance between domestic and foreign authors stems from the editors' belief that psychology as a science and as a profession should be emancipated from national boundaries, so that maximum integration of advances in the field can be effected, regardless of their point of origin.

The volume consists of surveys of the new literature in each of seventeen fields of psychology. Five chapters cover aspects of experimental psychology, including learning, vision, hearing, somesthesis and the chemical senses, and comparative and physiological psychology. Four pertain to clinical psychology, with reviews on abnormalities of behavior, clinical methods, psychotherapy, and counseling. Three other contributions survey child psychology, social psychology, and motivation. One chapter each is devoted to individual differences and recent developments in statistical theory and research design. A comprehensive bibliography of the new research and theoretical contributions follows each presentation.

Graduate students, researchers, and professionals in psychology and related disciplines will welcome these annual reviews for their inestimable aid in affording an overview of "what's new" in psychology.

Bellevue Psychiatric Hospital, SIDNEY YUDIN
New York City

THE COLLECTED PAPERS OF ADOLF MEYER. Vol. IV. *Mental Hygiene.* Edited by Eunice Winters. Baltimore: The Johns Hopkins Press, 1951. 522 p.

This is the fourth and last volume of Dr. Meyer's *Collected Papers,* the other three having been previously reviewed in this journal. These papers, collected, edited, and annotated by Miss Eunice Winters, and bound in an attractive four-volume format, present a series of his-

torical significance that belongs on the bookshelf of every serious student of psychiatry to-day. In spite of the fact that modern psychiatry is all but dominated by a strongly psychoanalytical trend, the basic theories of Meyer's common-sense psychobiology are still surprisingly accurate and appropriate, especially for the young student of human behavior, the psychiatric resident. In no field is this truer than in the field of mental hygiene.

As a social ferment in a primarily scientific field, the mental-hygiene movement in this country has helped to awaken public interest in the problems of mental disease, such as its epidemiology, heredity, prophylaxis, and the rooting out and exposure of improper, out-dated methods of treatment. And yet, as we read Meyer's papers on the subject—such as *The Problem of the Public Care of the Insane,* and the whole section of *Psychiatry and the Community*—we cannot but be amazed at how far we have come, as well as how far we have yet to go to meet Meyer's broad vision and specific appeals.

His recommendations concerning isolation wards, seclusion rooms, restraints; his astute comments on the use of the public press ("The medical profession must have been in a state of hysterics when it tried to meet the advertising skill of quacks with a code of ethics which is at absolute variance with the principles of the press to-day."); his observations on the shortcomings of the legal side of psychiatry ("To-day, with the best intentions, we have nothing to offset the bold and fresh fighting spirit of the artist of the legal game, except another set of feelings."); and his evaluation of the controversial subject of eugenics, (". . . we should be cautious about pushing everything to the point of legislative regulation. It is in the interest of civilization to provide principles and customs rather than laws, and to give the plain sense of the individual a chance to develop and to become effective.")—all emphasize repeatedly the universal and durable relevancy of his comments in this field. As Alexander Leighton says in his most excellent introduction: "He has stood out among men in our experience like one of his own Swiss Alps and no one of us has been able to see every slope and pinnacle."

The section, *Psychiatry and the Child,* is particularly interesting in that it contains the famous paper, first presented in 1925—*Mental and Moral Health in a Constructive School Program*—which contains the first published reference to his familiar "Life Chart." "The study of the total behavior of the individual and its integration as it hangs together as part of a life history of a personality in distinction from the life history of a single organ, that is our great interest in psychology and psychopathology." Some of his other remarks regarding the evaluation of a school system, and the problems of pupil, parent, teacher, and principal are singularly apropos to-day for the serious student of educational systems in general. As far as medical educa-

tion is concerned, his paper, *How Can Our State Hospitals Promote a Practical Interest in Psychiatry Among the Practitioners,* holds much of interest and value for those who are actively engaged in the education of general practitioners.

Psychiatry and the Problems of Maturity, the last section, contains several extremely interesting papers which are probably familiar to most of Meyer's students, especially the famous one on "Spontaneity" ("By the person's spontaneity, I mean that which the person may be expected to rise to and to rise with on his own, '*sua sponte,*' with his 'spons' and 'response,' and finally 'responsibility.' " Other papers of interest in this section are *Discontent—A Psychobiological Problem of Hygiene; Freedom and Discipline* ("The freedom school will either be a training for sound democracy in the sense of freedom with solidarity and self and group government, or a training mainly for revolt.") ; and *The Meaning of Maturity.*

The series is further remarkable for the admirable arrangement of the different papers and their careful placement in appropriate sections, and, not least important, for an excellent bibliography and index.

HARRIOT HUNTER

Division of Psychosomatic Medicine,
University of Colorado

DYNAMIC PSYCHIATRY. Edited by Franz Alexander, M.D. and Helen Ross. Chicago: University of Chicago Press, 1952. 578 p.

This valuable book is a collection of original papers by fifteen authors. It is divided into three sections. The first is entitled, *Concepts of Dynamic Psychiatry* and consists of four papers dealing with the fundamental concepts of personality development and function. The second section, *Clinical Psychiatry,* contains seven papers covering such subjects as the neuroses, the psychoses, emotional disorders in children, organic brain syndromes, and principles of psychiatric treatment. The third and final section of the book, *Influence of Psychoanalysis on Allied Fields,* consists of five papers whose subjects include psychosomatic medicine, animal psychology, clinical psychology, and anthropology.

The editors of this book have chosen their collaborators wisely. All of the authors are well-recognized authorities and each has done a remarkably good job on his own paper. Dr. Alexander himself has written the introductory paper in each of the three sections, which has helped to give the book a certain cohesiveness. The obvious advantage of having many authors lies in the wealth of personal experience and knowledge of the combined group. The disadvantages, although not great, are to be found in occasional repetition, certain

differences in style, and a tendency toward isolation of one chapter from another.

Dr. Alexander, after briefly outlining in the first section some of the early development of Freud's thinking, presents a good discussion of how psychoanalysis can adequately qualify itself as a true science. He points out that there are four main sources of error ordinarily present in the "common-sense type" of psychological approach. First, the person has no special reason to disclose his inner motivating urges to another person; second, the individual does not know many of his own motivations; and, third, there are great differences between the minds of every two people. This, of course, makes accurate communication difficult. It is even more of a handicap if one of the persons involved is neurotic, psychotic, or a child. The fourth source of error is that the observer's personality is not perfect and, therefore, has its own idiosyncracies which cloud the correct understanding of the patient's personality. Psychoanalysis takes into account these four sources of error and attempts to reduce each to a minimum. Dr. Alexander goes on to discuss such vital mental features as the mechanisms of ego defense and the functions, as well as the development, of the ego itself.

Dr. Benedek, in her chapter on "Personality Development," reviews again some of the areas covered by Dr. Alexander, but in addition presents a clear picture of the essential factors in the formation of the various structures within the personality. She traces the early stages of the ego and its relationship to the id. She also outlines the phallic phase of development and its relationship to the formation of the superego. She weaves into her discussion some of the factors that are important in the early mechanisms of ego defense. As she states, "The key to the understanding of all pathological processes is the evaluation of the adaptive task in respect to the total psychic economy."

In the section dealing with clinical psychiatry, one of the greatest weaknesses of modern psychiatry is unfortunately evident. Dr. Alexander utilizes some of the older terms, such as hysteria, as a basis for his dynamic discussion. This term, as well as others, have been eliminated from the latest nomenclature of the American Psychiatric Association. Drs. Saul and Lyons present a good discussion of "Acute Neurotic Reactions," particularly stressing the war neuroses. However, the student in reading this book would have some difficulty in forming his own clear over-all concept of the various categories of emotional and mental disorders, particularly if he tried to fit this presentation in with the latest nomenclature.

Dr. Margaret Gerard's discussion of emotional problems in children

is clear and useful. She approaches this area primarily from the standpoint of the problems to be found at each level of psychosexual development. She states that it is impossible to cover in such a chapter all of the emotional disorders of childhood. However, she does an admirable job of elucidating the most common ones. She divides them into infantile phenomena, motor disorders, conduct problems, common neuroses, vegetative disorders, and psychoses.

The chapter on "Psychoanalysis and Cerebral Disorders," by Dr. Brosin, is admirable for its attempt to clarify the relationship of analysis to many of the organic brain syndromes. This chapter was not intended to outline the organic factors involved in these conditions or the treatment of them from an organic standpoint and thus lacks some of the information that would be found in the usual textbook of psychiatry.

Another chapter that rates special mention is that dealing with psychosomatic medicine. Dr. Alexander, a pioneer in this area, presents a well-rounded summary of current thinking. He presents material showing the involved interrelationship between endocrines, autonomics, and psyche. He goes on to a further discussion of some of the most common psychosomatic conditions, such as asthma, hypertension, migraine.

The last section of the book also includes papers by such outstanding authors as Dr. Margaret Mead, Dr. David Shakow, and Dr. David Levy.

The entire book contains a wealth of psychoanalytic thought and theory. The style is clear and readable, as well as interesting. It is a book that should be of considerable value to any serious student of psychiatry.

O. Spurgeon English

Temple University Hospital, Philadelphia

Practical Psychology. By F. K. Berrien. 2nd edition. New York: The Macmillan Company, 1952. 640 p.

This is a revised edition of a book first published in 1944. The original purpose was "to provide a text to survey the chief problems in which applied psychology has made some contributions." In his preface to this second edition, the author states that "because of the remarkably stable nature of basic concepts in the expanding science of psychology, the underlying objectives of the first edition have not been altered." As is true in all revisions, there have been changes in emphasis and additions of new material.

The book is exactly what the author states it to be—"a survey of the chief problems in which applied psychology has made some con-

tributions." The range of topics included is so great that only the most superficial treatment of any one area is possible. This has required careful selection of material and a minimum of critical evaluation. On the whole, the author has chosen the best known studies in each area, and his short summaries and evaluations are fair and honest. The topics that he has chosen to include range from principles of mental health to methods of effective speaking and include discussions of problems of adjustment, problems in industry, problems of the consumer and advertising, problems of crime, and personal problems. There are nineteen chapters and a short appendix on statistics.

The book is obviously written for the student who is to be initiated into the broad field of applied psychology. He is to be acquainted with some of the fundamental problems and principles confronting those who work in the field and to acquire some idea of his own problems and how they might be helped by a knowledge of applied psychology. The book presents no challenge to the student nor any incentive for further study. He is simply given a fragmentary picture of a very large area of the social sciences. One assumes that there are to be other courses which will stimulate the student to further study and investigation in the field.

In as much as the author makes it perfectly clear at the start that the book was written purely as a survey course, it is difficult to be critical when this purpose has been so well attained. From the standpoint of mental hygiene, it does seem unfortunate that the author should have chosen to include some self-adjustment ideas without at the same time suggesting to the student where he might turn for further help if his problems cannot be solved in this very simple and superficial way. To be specific, the student is told that he may need to improve his reading skill and that this can be done by improving the rate of reading and the comprehension, but he is not told how complicated and difficult this may be and that there are reading clinics available in many colleges where he can go for help. The suggestion is made that he may need to make a better adjustment to his way of living, and the usual types of conflict are outlined, but he is not told that there are probably facilities available that he should feel free to use in the health and guidance departments of the school he attends.

Aside from this basic shortcoming, the book is a good over-all survey of the field.

ROY F. STREET

Grand Rapids, Michigan

PSYCHIATRY AND THE LAW. By Manfred S. Guttmacher and Henry Weihoffen. New York: W. W. Norton and Company, 1952. 476 p.

The rôle of psychiatry in legal trials, preparation for the sentencing of criminal offenders, and understanding of medical testimony in medico-legal problems has advanced enormously in the past fifty years. Texts on legal psychiatry have been scarce during this period and, when published, have been written from the standpoint of the lawyer, to acquaint him with a few medical terms usually couched in ancient phrases such as "monomania," "confusional insanity," and so on. These texts have little or nothing of the modern dynamic accent in psychiatry.

The volume under review supplies this deficiency and is, moreover, a joint effort by a psychiatrist and a lawyer, in this case two men who are eminently qualified through experience and soundness of view to form this amalgamation. The result is a text that covers all the areas in which psychiatry and the law meet—either in head-on collision or in amicable discussion—in daily activity in the courts. The book is written neither from the standpoint of the experienced medico-legal expert nor from that of the attorney who has often met psychiatric problems in practice. Rather, it is presented for the worker in either field who, through bitter experience or curiosity, wishes to understand this complex and not always rational relationship of law and psychiatry. In the fulfillment of this task, the book is admirable, since it is broad in scope, unprejudiced in attitude, and written clearly and simply from practical contacts rather than theoretical suppositions.

The book gives first a brief account of various types of mental disorders that are apt to be encountered in a medico-legal situation. These conditions really encompass clinical psychiatry; areas discussed are psychoneurosis and the psychopathic personality, sex offenders, organic brain disorders, mental deficiency, and the psychoses. The second section deals with the psychiatrist in court and on the witness stand. The last third of the book deals with commitment procedures and the problems revolving around them, and areas of conflict between the law and psychiatry in its interpretation of the degree of incompetency that is sufficient to denote criminal irresponsibility. There is a final chapter called, *Ounces of Prevention*, which deals more particularly with criminology. A section on head injury is included under "Organic Brain Disorders."

This categorizing of the various sections does not do justice to the wealth of material encountered in the courts and in cases presented for examination to a psychiatrist in a clinic attached to a court. The case reports, which are liberally distributed throughout the book,

bring up pertinent and varying points that illustrate many situations, some of them totally unexpected, in the complex area of criminal acting-out of neurotic impulses. The technical discussions of psychiatric syndromes, though not complete, are clear and represent a balanced view of to-day's psychiatric practice. The chapter on the psychoses, though relatively brief (in the section on schizophrenia only one case is cited of this criminologically important group), is clearly stated. Incidentally, the reviewer is not convinced that the story of King George III and his recurrent mania (p. 70) is particularly pertinent to the medico-legal student of to-day even though it plays an important rôle in the development of psychiatric history.

At almost any point in the book one is tempted to take off into realms of specialization which the authors have been careful to avoid to keep the discussions within the limits of one volume. For example, on page 110, the statement that the "history of the legislative process in regard to sexual offenses lends confirmation to the view that this legislation has originated primarily from emotional reactions," is one that touches on a most vital socio-psychologic problem. In fact, the history of sex-offender laws is the history of the cultural defense against sexuality throughout the centuries, and it plays an unappreciated part in the conduct of everyday court activity concerning criminal cases (sex offenders) and their disposition. In this regard the authors have, in their discussion, ironed out the complexities of this field sufficiently to give a broad picture of the sex offender, but this reviewer can hardly agree that the sexual-offense problem is "an already hopelessly complex" one. It may be complex, but it is not hopeless, as indicated by their review of the recent legal attempts, through the sex-psychopath laws, somehow to bring psychiatric know-how into the sexual-psychopath field. Although the laws have not yet been implemented by sufficient numbers of psychiatrists trained in the special field of psychiatric criminology, still the preparatory educative process of bringing crime and psychiatry into relation in the public's mind has been started. Without this preparation no effective work, in the long run, can be done in treating sex offenders.

The question of the psychiatrist on the witness stand is dealt with very realistically in several chapters on the subject. To this reviewer, it seems that the legal position cannot be too often explained that "an expert witness is only a witness, he does not decide the case" (p. 211). It is of importance for every physician to realize that the combatant atmosphere of the courtroom is not an artifact, but a reflection that the law court is an area of conflict, not a scientific proceeding. This, the authors have well described. Some of the problems of "the battle of experts" can be partially solved, it seems to the reviewer, by removing some of the emotional overgrowth that the authors indicate

has grown up from the side both of the physician and of the attorney in the actual courtroom situation.

There is much information on other than criminal matters; for example, the problem of sterilization of the defective, the question of wills, of marriage and divorce, of the relation between testimony and truth from the standpoint of emotional factors in the witness, and so on. Further detailed report on the content of the book would simply repeat much of the authors' material.

Suffice it to say that this is a modern analysis of a very broad field, made with restraint and dispassionate judgment. To this reviewer, its greatest value would seem to be in explaining to the legal student or practitioner the meaning of psychiatric thinking in relation to law. Although the reviewer is less competent to judge the legalistic material, the citations and case reports seem to be apt and instructive. It is a realistic study and undoubtedly will be of value to students and practitioners in legal and psychiatric fields.

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HEREDITY IN HEALTH AND MENTAL DISORDER. By Franz J. Kallmann, M.D. New York: W. W. Norton and Company, 1953. 278 p.

The book presents the Salmon Memorial Lectures delivered by Dr. Kallmann in 1952. In them Kallmann attempts to establish the science of genetics as a fundamental element in modern psychiatry, mental hygiene, and public health, the latter being treated properly as including the former.

The first lecture sets forth data on the relation of heredity to mental health. Much of this section had to contain basic concepts of genetics and other introductory material, particularly the background necessary to enable the lay reader to recognize the significance of twin studies. Nevertheless, there is useful discussion of the contributions of heredity and environment as they can be seen to influence life patterns. The discussion of senescence is most interesting and is well documented. As other authors have found, however, it is not easy to discuss the heredity of normalness; physicians tend to think in terms of the unusual and abnormal, and this trap is not escaped by Kallmann in spite of his best efforts.

The second part concerns heredity in relation to mental disorder. Kallmann makes a special point of the association of variations in body weight and schizophrenic episodes. The chapter presents the data on the inheritance of the various mental illnesses quite fully. His own extensive studies form a considerable and highly significant part of the data. There is a tendency to be rather more tolerant of the

conclusions regarding body type in relation to psychiatric illnesses than the quality of the data in this field seem to justify to many observers. The discussion of heredity in relation to mental deficiency of non-specific type gives more attention to the possibility of pre- and para-natal damage than is the case in the older discussions of this subject. Heredity is credited with the responsibility for from 50 to 80 per cent of cases in contrast to the older studies in which these and other post-conceptual damages were not recognized.

The last lecture, *Contributions of Genetics to Mental Health Planning,* is largely a plea that genetics be recognized as a basic part of psychobiological science and that it be not engulfed in what Kallmann obviously believes is a tremendous over-accentuation of environmentalism and psychodynamics at the present stage of development of psychiatry. His plea for more research in genetics is certainly a wise one. There is more than a trace of self-pity to be discerned in these emotional pages, however, and an underlying attitude of expecting to be misunderstood that seems to this reviewer to weaken the effect of the plea. Kallmann has for so long been lonely as one of the very few human geneticists that this is understandable. It is unfortunate, however, that this note should have crept in at the moment of a triumph for himself and his specialty—the giving of the Salmon Lectures.

The book is described on the dust cover as profusely illustrated, as indeed it is. Many of the illustrations seem to be for the purpose of making good the publisher's boast. It is generally agreed that dizygotic twins can be very different and monozygotic twins very much alike. Kallman's collection of photographs is interesting and of scientific importance, but in many instances in this book contribute nothing to the text and frequently interfere with smooth reading by interrupting the context. Also, probably because of the illustrations, the book was printed on highly glazed paper, which makes for irritating reflections that detract from the pleasure of reading it.

Genetics is a science fundamental to human biology, to psychiatry, and to mental hygiene as a part of it. It is a disappointment that this book does not present its case more attractively.

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NOTES AND COMMENTS

Third Annual Meeting of The National Association for Mental Health

The National Association for Mental Health held its Third Annual Meeting in Cleveland, Ohio, from October 31 through November 2, 1953. Five hundred representatives from 300 state and local mental-health associations attended. Also represented were the National Institute of Mental Health, the American Psychiatric Association, the Neuropsychiatric Division of the Veterans Administration, and many other professional and governmental organizations.

The theme of the meeting was "Mental Health—Everybody's Business." Representatives of the clergy, industry, law-enforcement agencies, and public-health and parent-teacher groups developed this theme in relation to their own fields.

The Rev. Seward Hiltner, professor of pastoral theology at the University of Chicago, represented the clergy. Industry's view was expressed by Dr. J. Elliott Janney, industrial psychologist, of Rohrer, Hibler, and Replogle in Cleveland. Mr. John M. Gleason, Chief of Police of Greenwich, Connecticut, spoke for the law-enforcement agencies. Public health was represented by Miss I. Estelle Dunlap, of the Frances Payne Bolton School of Nursing in Cleveland; and parents and teachers, by Mrs. Russell C. Bickel, Secretary of the National Congress of Parents and Teachers.

Among the high lights of the meeting were addresses by Dr. Karl Menninger, of the Menninger Clinic and Foundation, Topeka, Kansas, and by Mary Jane Ward, author of *The Snake Pit*.

Dr. William Malamud, Director of the Committee on Research in Dementia Praecox of The National Association for Mental Health, reporting on the program, stated: "Our students of genetics have been able to prove the significance of the constitutional endowment of the individual in the development of the disease, but equally important is the fact that it has been possible to demonstrate that in a large measure these factors serve to make the person more vulnerable to the disease, provided certain stress situations develop which bring forth this constitutional weakness, and that the disease, schizophrenia, is really a resultant of a combination of constitution and early environmental factors. This knowledge can now be utilized in the development of a rational program of prevention."

Other reports of special interest were those by Dr. George S. Stevenson, National and International Consultant of The National Association for Mental Health, who stated that mental illness is the

most costly of all the illnesses afflicting the American people, in terms both of financial expenditure and loss and of personal and social disaster; by Mr. Raymond G. Fuller, who has just completed a two-year study of the administration of state mental-health services, and who found that the states were still using "stone-age tools" in their administration of mental-health services; and by Dr. Erich Lindemann, who said that the field of preventive psychiatry lagged far behind preventive efforts in other health fields. Dr. Lindemann stated that psychiatry has lately turned more and more away from exclusive preoccupation with the needs of the individual patient to the emotional needs of the family and the community.

Richard Weil, Jr., formerly president of Macy's New York store, was elected President of The National Association for Mental Health. He told the convention that the mental-health associations would need at least ten million dollars to do an adequate job next year. This fund, he said, would be used for (1) allocation of grants for new research on mental illness; (2) allocation of grants to medical social work and allied training institutions for the expansion of programs for the training of personnel in the psychiatric and mental-health fields; (3) fellowships and scholarships to students in these fields; and (4) the establishment of information and reference centers in communities where none exist to-day.

Mr. Weil said that The National Association for Mental Health is now in the process of setting up a scientific research committee, which will serve as a clearing center for information on all research being carried on in the field of mental illness and which will select areas of research to be financed by grants from the association.

Grants for Research in Schizophrenia

Grants totaling $64,795 have been allocated by The National Association for Mental Health for research in schizophrenia during the coming year.

The grants were made from a $75,000 fund provided by the Supreme Council, 33rd Degree, Scottish Rite, Northern Masonic Jurisdiction, which has given a total of more than a million dollars in the last twenty years for this purpose.

Schizophrenia accounts for one in every five new admissions to state mental hospitals each year, and over half of the 650,000 patients in mental hospitals to-day are suffering from this disease. The objectives of the schizophrenia research program are to learn more about the causes of the disease and the ways in which it can be successfully prevented and treated.

Grants of $56,050 were made in support of ongoing studies, and

initial support was given to three new projects. These include a grant of $4,000 to the University of Michigan for a study by Dr. Ralph D. Rabinovitch of childhood schizophrenia; a grant of $3,000 to Columbia University for a study by Dr. Sigmund Pietrowsky of projective techniques in early schizophrenia; and a grant of $1,745 to Dr. Alfred Washburn, of the Child Research Council of the University of Colorado, for the purchase of equipment to be used in connection with studies of the psychological development of children.

National Committee on Aging Holds Annual Meeting

The annual meeting of the National Committee on Aging was held at the Hotel Roosevelt, New York City, on November 11. About a hundred representatives of management, insurance, labor, medicine, public health, and welfare attended the one-day meeting. The committee is sponsored by The National Social Welfare Assembly.

American Airlines policies on retirement were discussed at the morning session of the committee by Allen Gebhart, director of employee relations for the company. Mr. Gebhart told the group that while the company had a flexible, non-compulsory retirement-age policy for most employees, pilots were automatically retired at the age of sixty. Experience over a fourteen-year period had proved, he said, that after age fifty-five, such factors as reaction time begin to decline, and sixty had been established as the latest "safety age" for pilots.

The company, which has a program of preparation for retirement beginning five years before retirement age, now pays retirement benefits to 85 employees. Many of these have been transferred to less demanding jobs within the organization; others have turned to farming, writing (one former pilot has written three best-sellers), and teaching. Experienced pilots, grounded because of age, make the best instructors for younger pilots, he said. He reported that piloting the modern transports had become a much more demanding and complicated job because of safety requirements and the necessity to master the instrument set-up.

Bernard Greenberg, of the pension and benefit department of United Steelworkers, speaking at the same session from the point of view of labor, said that the three most important problems confronting unions working in behalf of older employees were the need for flexible systems of transfer within organizations for the employee who wishes to work past retirement age and is physically able to do so; the need for preparation for retirement; and more adequate provisions for pension and medical care for retired employees.

Lee Belcher, of Pillsbury Mills, reported on a survey of management in a number of Minneapolis firms to determine specific problems of

employment of older workers. He had found that the joint management-union boards set up to make decisions about retirement, transfer, and other problems, had met with great success in many companies.

An experiment in the placement of retired workers in part-time jobs was reported by a representative of the Federation Employment Service conducted by the Federation of Jewish Philanthropies. It has been found that if medical examination shows that the applicant is able to work four hours a day, these placements are successful.

Mrs. Pearl Ravner, representing the Women's Bureau, U. S. Dept. of Labor, described two studies currently being conducted by the bureau on the training and re-training of middle-aged and older women for paid employment. The "age-barrier" for women is now thirty-five, she reported—even among office workers, where a great shortage exists. Among women currently seeking employment, many have never worked before and many others are "skill-rusty" because they have not worked since before marriage. A great many of these women are entering the labor market because of the illness or death of their husbands.

Speaking at the luncheon meeting, Dr. Bernard Covner, senior associate of Dunlop and Associates, "human engineering" firm of Stamford, Connecticut, discussed "Implications of Human Engineering for Older People." Dr. Covner explained that human engineering, which brings to bear the combined skills of psychology, engineering, and mathematics on the designing of equipment, products, work processes, and work situations, can be applied successfully to increase the comfort, safety, and simplicity of operation for people in business and industry, in the home, and in institutional life. He predicted that our increasingly aging population would bring pressures on the human engineering field to make a concerted attack on redesigning with this group in mind—not only in industry, where the older worker has been found to be an asset, but in various living situations also.

Dr. Frederic D. Zeman, Medical Director of the Home for Aged and Infirm Hebrews, New York City, appearing on the afternoon program with a team of psychiatrists and psychiatric social workers, described progress in the use of psychiatric techniques to halt the pace of mental deterioration among patients at the home. He emphasized the importance of work with staff on their attitudes toward the senile patients themselves, and stressed the necessity for allowing older people to function as fully as their capacities will allow in an atmosphere that is kept as congenial and favorable as possible.

The meetings preceded a two-day session of The National Social Welfare Assembly and its 68 affiliated national health, welfare, and recreation agencies.

Sixteenth Annual Medical Symposium of Duke University

The Sixteenth Annual Medical Symposium of Duke University was held at Durham, North Carolina, on December 2. The symposium, which was attended by doctors from the Carolinas, Virginia, and Tennessee, was on the theme, "Psychiatry for the Non-Psychiatrist."

Some of the problems of rural psychiatry were discussed by Dr. Roger W. Howell, of the University of North Carolina. A number of factors operate against successful rural psychiatry to-day, Dr. Howell said. They include the fact that "the supply of personnel who might provide services without further training is limited in rural cases. . .; personnel who have completed their training seem to want to remain in centers of population, rather than go into rural areas to practice.

"Training programs for people who already live in rural areas are going on in many places, but the nature of the training is complicated and time-consuming. . .

"There seems to exist in many rural areas some resistance to establishing facilities like mental-hygiene clinics. . . Rural psychiatry seems to involve the psychiatrist more as a consultant than as an individual therapist, and as a consultant to other members of the psychiatric team who have had only partial training. Problems of how to work together seem to be frequent and do interfere considerably with the success of a program."

Among the measures that are being taken to meet these problems, Dr. Howell said, are (1) better preparation of general practitioners of medicine, so that these doctors can meet needs without referring patients; (2) training of others who can help locally—the clergy, public welfare, health, and education personnel, and professional persons who deal with people's health and welfare, such as lawyers, dentists, and pharmacists; and (3) state and federal support to provide services in rural areas.

In addition, Dr. Howell said, "The importance of the activities of local, state, and national mental-health societies should not be overlooked as sources of valuable assistance."

Another speaker at the meeting, Dr. Spafford Ackerly, professor of psychiatry and chairman of the department at the University of Louisville School of Medicine, stated that "too often the aged accept their aches and pains as normal for that age. They are not normal. They are pathological, and, being pathological, we can do something about them.

"So let the old people complain, let them gripe on all the problems that affect them. That is the only way we are going to make progress in the treatment and prevention of these problems.

"One cannot talk of old age as an entity. Growth and development to that 'fine climax of maturity' is not synonymous with adulthood, early or late. It is not given to us—it is an achievement, the road to which starts very early."

Dr. Ackerly quoted another expert on the problems of aging to this effect: " 'Pessimism is the greatest foe of old age. The pessimism of our families. The pessimism of management and physicians and educators, and above all the pessimism of old age.

" 'No greater task can be given our churches, our government, our schools, our social agencies, and our professions than to rid us of the prevading pessimism, so that our communities will be able to take our old folks "off the shelf" and out of the corner.' "

An army psychiatrist, Col. Albert J. Glass, Chief, Department of Neuropsychiatry, Brooke Army Medical Center, Fort Sam Houston, Texas, said that America's family doctors will have to be psychiatrists, too, in case of an enemy atomic attack. Experience in both world wars and in Korea has shown "that the basic cause of mental breakdown in battle (and in civilian disaster) is the crippling effect of fear," Col. Glass said. "Fear has been a strategic weapon of battle since the recorded history of warfare."

In combat, fear is combated by rigorous army training, by unit morale, and by the force of "action" that "drowns tension," Col. Glass continued. In addition, combat troops that work and live together for long periods develop friendships and attachments that override fear in emergencies.

Greater problems arise in civilian disaster periods, because military discipline is missing. "In sharp contrast to the well-structured military organization is the unorganized civil populace, which includes small children, the aged, the infirm, and the sick.

"Such a heterogeneous, undisciplined group can hardly be expected to withstand terror, deprivation, and dislocation without a good deal of panic and confusion, especially when there is considerably less opportunity for removing tension by appropriate action."

The general practitioner "is well-equipped by experience and community status to function in a psychiatric capacity" at these times, Col. Glass stated. "As the family physician, the general practitioner has considerable knowledge of his patients, that includes their background, family and domestic situation, economic difficulties, and personality characteristics.

"He is, therefore, in a strategic position to understand their emotional reactions and, due to their trust and confidence in him, has attained a favorable doctor-patient relationship which is the prime prerequisite for successful psychiatric therapy."

The only way to prevent "panic and psychiatric casualties" is "a

prepared defense organization in which there are capable and trained leaders," Colonel Glass declared.

"To this end, the civil population must be systematically organized, block by block. Initially, in any enemy attack, some confusion is inevitable, but if individuals so involved have a specific function and are part of a definite group, headed by a leader, purposeful activity will result that will prevent panic and rout.

"It is toward this goal that we must direct some of our civil defense efforts."

The Ethel Perrill Memorial Awards

The Kansas Association for Mental Health has announced that annual awards, to be known as The Ethel Perrill Memorial Awards, will be made to the Kansas newspaper and the Kansas newspaperman who have made the most significant contributions to mental health during the year.

The award to the newspaper is symbolized by a plaque, suitably inscribed, which remains in the newspaper's possession for the following year. The award to the newspaperman is $50.00 in cash.

The winners of the 1952 award were Robert Townsend and the *Topeka Daily Capital* for Townsend's series of articles on nursing homes. Honorable mention went to Joe Lee and the *Topeka State Journal* for an editorial entitled, *When Can I Go Home?;* to John P. McCormally and the *Hutchinson News-Herald* for features and editorials; and to Mary Grice and the *Wichita Eagle* for mental-health coverage.

These awards are made as a bequest of Miss Ethel Perrill, a native Kansan, graduate of Kansas Wesleyan University and of the University of Denver School of Social Work, whose pioneering work on behalf of the mentally ill laid much of the foundation of understanding for the progress we enjoy to-day.

Any Kansas newspaper and any editorial employee of such a newspaper are eligible for the awards.

News stories, features, or editorials, either as single pieces or as a series, may be submitted for the competition by the newspaper in which they appeared. These should be identified with the name of the paper, the date of publication, and the name of the writer. More than one story may be submitted by a newspaper.

The news stories, features, or editorials will be judged by a committee of newspapermen and the president of the Kansas Association for Mental Health for the effectiveness with which they point out, discuss, or demonstrate mental-hygiene information, mental-health facilities, or mental-health needs.

Entries should be submitted to: Mrs. Helen Morrison, Secretary,

Kansas Association for Mental Health, Masonic Building, 10th and Van Buren, Topeka, Kansas.

American Psychiatric Association Protests Political Interference with Administration of Public Mental Hospitals

Political interference with the administration of public mental hospitals in various states seriously threatens the gains made in recent years in the care of the mentally ill, the American Psychiatric Association believes. According to a recent statement by its president, Dr. Kenneth E. Appel, of Philadelphia, "in several states newly elected administrations have yielded to the temptation to embroil the state mental hospitals in party politics. Under one pretext or another, they have removed physicians and other professional personnel hired by a previous administration. They have cut already entirely inadequate hospital budgets under the guise of 'economy.'

"The mental patients and their families are, of course, the ones who suffer most.

"Care of the mentaly ill in the U. S. is traditionally a responsibility of the states," Dr. Appel pointed out. "The state hospitals care for about 90 per cent of all the hospitalized mentally ill (nearly 700,000) at a cost of more than half a billion dollars annually. There is no hope of reducing this staggering burden unless the doctors, nurses, social workers, psychologists, psychiatric aides, and others can work in a hospital atmosphere conducive to sound treatment, training and research.

"It is axiomatic that a good hospital abhors politics. The best public mental hospitals are in those states that have long since given them professional hospital personnel status and tenure, and protected them from the ebb and flow of political change and preference.

"The American Psychiatric Association urges political leaders everywhere to take stock of the incalculable damage they do when they sacrifice the professional staffs of our mental hospitals to a fleeting political advantage."

Schools of Nursing of New York State Department of Mental Hygiene Affiliated with Colleges and Universities

Some 200 first-year students in 13 schools of nursing of the New York State Department of Mental Hygiene have enrolled as freshmen in arts and science courses at colleges and universities, according to a recent announcement by Dr. Newton Bigelow, Commissioner of Mental Hygiene. Arrangements for the affiliation were made with the University of Buffalo, Adelphi College, Harpur College, University of

Rochester, St. Lawrence University, Utica College, Geneseo State Teachers College, and Orange County Community College.

"The affiliation program, which began on a limited scale three years ago and has this year been expanded, enables student nurses in the basic 3-year department schools to gain college credits while receiving their nursing education," the commissioner said. "This is in line with present-day trends in professional nurse education." He added, however, that the nursing arts will be taught from the beginning of the course in the home hospital, where the student nurse has direct contact with patients. College and department-school faculties will coöperate in planning integration of the academic courses with practical application.

Student nurses will attend college four days a week, taking the same courses as regular science students, having full use of the college classrooms, laboratories, and libraries, and participating in college activities.

Entering into the affiliation are the department schools of nursing at Creedmoor, Kings Park, Central Islip, Pilgrim, Gowanda, Binghamton, St. Lawrence, Rochester, Willard, Middletown, Marcy, and Utica state hospitals, and Craig Colony.

Pioneers in the teaching of psychiatric nursing, the schools of the department of mental hygiene have graduated more than 9,000 professional nurses, men and women, since 1886, when the first class of seven was graduated at Buffalo State Hospital. In addition, Dr. Bigelow stated, students from 77 of the 95 general-hospital and collegiate schools of nursing in New York State and from 10 schools in other states attend the department's schools of nursing for twelve weeks of education in psychiatric nursing.

Committee Set Up to Certify Physicians As Qualified Mental-Hospital Administrators

The American Psychiatric Association has set up a committee to certify physicians as "qualified mental-hospital administrators." The committee will conduct examinations periodically and issue qualification certificates to successful applicants.

The step has been taken, according to Dr. Kenneth E. Appel, president of the association, to help ensure that the chief executives of mental hospitals not only shall be physicians adequately trained in psychiatry, but shall also be skilled in business and personnel management, community relations, budget control, procurement, and other essential administrative techniques.

Ever since 1844, Dr. Appel stated, the American Psychiatric Association has maintained that the chief executives of mental hospitals must be physicians who have specialized in psychiatry. The associa-

tion regards as unsound proposals to separate "administrative" from "medical" responsibility in the hospital, with corollary suggestions that doctors should confine themselves to medical matters only. It believes that all mental-hospital operations bear a direct relation to the therapeutic progress of a patient and, accordingly, that only a physician may assume total responsibility for them.

This position is held, Dr. Appel emphasized, without prejudice to that large body of laymen who serve as skilled and indispensable executive assistants to the chief executives of the mental hospitals.

The certification system is just one of several steps the association has taken in recent years to raise standards of treatment and care for the mentally ill. The association also sets standards for and inspects and rates mental hospitals. It operates a technical information service and conducts educational institutes for mental-hospital personnel. It approves training courses for nurses in mental hospitals.

The new Committee on Certification of Mental Hospital Administrators is headed by Dr. Francis J. Braceland, Hartford, Conn. Other members are Drs. William B. Terhune, New Canaan, Conn.; George W. Jackson, Topeka, Kansas; Walter H. Baer, Peoria, Ill.; Granville L. Jones, Williamsburg, Va.; Frank F. Tallman, Los Angeles, Calif.; Arthur M. Gee, Essondale, British Columbia, Canada; Harold W. Sterling, North Little Rock, Ark.; Jack R. Ewalt, Boston, Mass.; and G. Wilse Robinson, Kansas City, Mo. Consultants to the committee are Drs. Winfred Overholser, Washington, D. C.; Mesrop A. Tarumianz, Farnhurst, Delaware; and Hayden H. Donahue, Oklahoma City, Okla.

The secretary of the committee is Dr. C. N. Baganz, Manager, Veterans Administration Hospital, Lyons, New Jersey. Forms for applying for certification and other information may be obtained from him.

Three New Projects Started by Community Research Associates

Three American communities, each typical of its kind, but widely separated as to geographic location, population, history, and personality, have been selected by the Community Research Associates, Inc., to test and demonstrate methods of prevention and control of family problems in a new million-dollar, four-year project. The three are Hagerstown, Maryland, with a population of 70,000 and a great historical tradition; Winona, Minnesota, typical mid-western town with a population of 40,000; and San Mateo, California, comparatively new and fast-growing metropolitan area of 300,000. All three study locations will be county-wide in scope to gather both urban and rural data.

Three foundations are underwriting the projects with funds aggregating $1,250,000. They are The Grant Foundation of New York, the

Hill Family Foundation of St. Paul, and the Rosenberg Foundation of San Francisco. The three new projects will be under way by January, 1954, and will help check findings concerning social-problem patterns that were uncovered in the Community Research Associates' original St. Paul study.

Out of the original study by Community Research Associates came the startling fact that about 6 per cent of the population were absorbing well over half of all health and welfare funds, both public and voluntary. Further, it was disclosed that more than half of these people had developed multi-problem patterns, and that to effect rehabilitation and prevent recurring cycles of misery, they would require family-centered treatment rather than the scattered attempts by representatives of many agencies treating various facets of the problems.

A portion of the million and a quarter fund has already been spent on a classification study of family problems and their relationship to marital partnerships. Further experimentation with the details of the classification study, and the setting up of "rates of disordered behavior," will be a part of the new projects. Five main categories of "rates" of breakdown will be systematically gathered, evaluated, and interpreted during the four-year projects. These categories are Unsocial Youthful Behavior, Unsocial Family Behavior, Other Antisocial Adult Behavior, Maladjustment Mortality, and a Composite Rate which consists of an unduplicated count of families and individuals involved in one or more of the detailed categories making up the major rates.

The methods to be employed have recently had a six-months try-out in Winona, where facts already uncovered bear out the findings of the St. Paul study. Of the Winona families receiving some service from one or more social agencies during the period under review, 7.5 per cent were dependent. In St. Paul this figure was 6.3 per cent. Of these recipient families, almost half were suffering from two or more of the serious major difficulties: financial dependency, ill-health or disability, disordered behavior, and maladjustment. This group comprises quite a small proportion of the total families or households in Winona County, in fact only 5.8 per cent. But the figure is strikingly close to St. Paul's figure of 6.1 per cent for the same grouping. It is this small group for whom more than half of the health and welfare funds are being expended.

The inter-connectedness of individual patterns of ill-health, maladjustment, crime, and dependency with general family breakdown requires a whole new approach, according to Bradley Buell, Executive Director of Community Research Associates, and author of the book on the St. Paul study, *Community Planning for Human Services.*

"We are trying to forge whatever new tools are needed to tackle

these problems effectively," Mr. Buell said. "Basic to our efforts is the participation of existing services in family-centered treatment plans and follow-up procedures. What has been missing from the community picture is coördination and integration of services, not only at the executive level, but at the level of operation."

Commenting on the criteria by which the three test areas were selected, Mr. Buell said there were four major guides:

1. There must be community leadership of high intelligence, pioneering spirit, and receptivity of a coördinated plan. All three communities meet this specification.

2. There must be an uncomplicated agency set-up with clearly defined and manageable lines of responsibility. All three cities have compact, well-managed community services.

3. There must be good basic health and welfare services, capably staffed, to carry out the coördinated planning in the rehabilitation of badly disorganized families.

While the same basic methods of study, classification, tabulation, and evaluation will be carried on in each of the three communities, each will have a different "focus" or specialized study.

In Hagerstown, Md., which has been a research and experimental station for the United States Public Health Services for a long time, the focus will be on family health problems. In Winona, typical of a large number of middle-western, urban-rural communities, the focus is on dependency. The study in San Mateo County will be focused on disordered behavior.

In all three cities during the next four years specific and precise methods of coördinated procedures will be developed, perfected, and made ready for use by every American city that wishes to improve its health and welfare services, and at the same time to prevent problems that tend to destroy American family life.

Department of Mental Hygiene Opens New Child-Guidance Center in Rochester

A new child-guidance-clinic center has been opened in Rochester by the New York State Department of Mental Hygiene, according to a recent announcement by Dr. Newton Bigelow, Commissioner of Mental Hygiene. A traveling team of clinic personnel, consisting of psychiatrist, psychiatric social workers, and psychologist, will staff the Rochester center and conduct four weekly community child-guidance clinics in the area.

The opening of this center in Rochester brings to a total of 12 the number of child-guidance-clinic centers maintained by the department, each staffed by a traveling clinic team. A total of 59 New York State communities receive regularly scheduled service from these centers.

Provision has been made in state appropriations for the addition of two more clinic teams, which are to be appointed as soon as the professional personnel can be obtained, the commissioner said.

Play Therapy for Mentally Retarded Children Being Tested at Rutgers University

Eight little boys and girls, with troubled minds and anxious parents, and an attractive young doctor of psychology are players in a research story now unfolding on the Rutgers University campus.

The youngsters, aged from three to seven and suspected of being mentally retarded, have been brought here to the University College Psychological Clinic by parents who want to know exactly what is wrong with them, and, above all, whether their conditions can be improved.

Dr. Florence B. Ricciuti, twenty-eight-year-old clinician on Dr. Anna S. Starr's clinic staff, hopes to have some of the answers soon. She is conducting "Rutgers Research—Project No. 230," a program designed to appraise the effectiveness of play therapy on mentally retarded young children.

The Rutgers play-therapy method, tested last year and applied formally for the first time this fall, calls for individual testing and observation of the children in half-hour sessions twice a week for twelve weeks.

"Retarded children," Dr. Ricciuti explained, "often do not respond well to routine testing conditions. They tire easily, and considerable time is required to diagnose their problems and determine their trainability."

The play sessions are held in a specially designed playroom in the basement of the clinic with only Dr. Ricciuti and the child present.

A few rules are explained to the child. He must not hurt himself or the teacher, and he must not deliberately break the toys. Otherwise he is allowed complete freedom for about fifteen minutes. A "structured" play period, during which Dr. Ricciuti presents certain tasks to the child, using form boards and the like, comprises the other half of the session.

At the end of approximately twelve weeks, she prepares data sheets on the child's ability, personality, and social maturity.

His motor cördination—how he walks, runs, skips, and carries things—his form perception and visual motor coördination, and his speech, are all charted, along with the results of general-ability tests. His general emotional tone, his tolerance of and reaction to frustration, his interpersonal relations with children and adults, and how he plays are also recorded.

These records, correlated with his performance in tests taken at

the beginning of the program, and with his response to the early play periods, permit Dr. Ricciuti to estimate his trainability in areas of self-help and social maturity and to evaluate his personality.

The progression charts on two children with identical I.Q.'s sometimes show a remarkable difference, Dr. Ricciuti said. "One child actually may have more ability than his test score indicates and, given sufficient time for study and instruction, he will show far greater improvement than the other." Thus, she added, educational plans for the two children will be quite different.

Although the child is the focal point of the study, his parents often are equally in need of behavior modification. Parents of retarded children sometimes develop guilt feelings or an actual dislike of the child, Dr. Ricciuti pointed out. Others become overly fond and protective of the child. Both situations only serve to increase the child's problem.

To meet this problem, the psychologist schedules periodic conferences with the parents and, through counseling, attempts to determine their emotional needs in accepting the child and his problem.

"It is our hope that this study will aid the retarded child, the family, and the community," Dr. Ricciuti concluded.

The National Society for Crippled Children and Adults Awarded Distinguished Service Certificate

For outstanding achievement and service through its nationwide program of employment for the crippled, the National Society for Crippled Children and Adults, the Easter Seal Society, has been awarded the Distinguished Service Certificate by The President's Committee on Employment of the Physically Handicapped. The award, which is the highest honor that can be conferred by the committee upon a coöperating group, was announced by Vice-Admiral Ross T. McIntire, chairman for the nation's capitol.

The Easter Seal Society was cited for pioneering many new programs and projects for the handicapped, and for the public attention its activities have focused on the national program to employ the physically handicapped. This service has been carried out by the society through its vast network of more than 2,000 state and local Easter Seal affiliates located in every state in the nation, District of Columbia, Alaska, Hawaii, and Puerto Rico.

Dr. William T. Sanger of Richmond, Virginia, is president of the society and Lawrence J. Linck, its executive director.

Each year the society grants fellowship awards to qualified counselors, guidance teachers, and other professional persons for specialized training in the placement of the cerebral palsied and

other severely handicapped workers. This training is designed to encourage public and private agencies to increase their services for the handicapped and to inform industry of the vast national resource available in the employment of the disabled.

The society also operates a free national personnel registry and employment service, a personnel clearinghouse, to ensure the best use of the services of those qualified by training, experience, and interest in work with the physically handicapped.

Philip E. Ryan Appointed Executive Director of the National Health Council

Dr. A. W. Dent, President of the National Health Council, has announced the appointment of Philip E. Ryan as executive director of the council, to succeed Dr. Thomas D. Dublin, who has resigned to accept a position with the National Foundation for Infantile Paralysis.

The National Health Council, established in 1921 to promote the health of the people of the country through its members, now has a membership of 40 national official and voluntary agencies.

Mr. Ryan, who has been serving as special assistant to the director of the National Social Welfare Assembly, recently returned from Korea, where he was an adviser on health, welfare, and education in the civil assistance program of the U. S. Army. He was formerly Chief of Mission for the International Refugee Organization in the U. S. Zone of Germany.

Mr. Ryan directed the war-time foreign war-relief activities of the American National Red Cross, making a number of trips to Europe and the Far East. Before joining the Red Cross in 1939, he had been Executive Secretary of the National Committee on Care of Transient and Homeless.

A graduate of Fordham and Notre Dame Universities, Mr. Ryan has also done graduate work at the New York School of Social Work. He is the author of several social-work publications, including *Migration and Social Welfare,* published by the Russell Sage Foundation.

Courses Available

The University of Minnesota will present a continuation course in neurology for general physicians and specialists from January 25 to 30, 1954, in the Center for Continuation Study. Diagnosis and management of the more commonly encountered neurological disorders will be stressed.

The guest faculty will include Dr. Madison H. Thomas, Chairman, Neurology Section, Department of Psychiatry, University of Utah; Dr. A. Theodore Steegman, Chief, Department of Neurology, Uni-

versity of Kansas Medical Center; and Dr. Adolph L. Sans, Head, Department of Neurology, University of Iowa Medical School. As an integral part of the course, the annual John B. Johnston Lecture will be presented on the evening of January 27 by Dr. Andrew T. Rasmussen, professor emeritus of anatomy, University of Minnesota Medical School. The course will be presented under the direction of Dr. A. B. Baker, director of neurology, who will be joined by other members of the faculty of the University of Minnesota Medical School and the Mayo Foundation. Lodging and meal accommodations are available at the Center for Continuation Study.

A continuation course in child psychiatry for general physicians, pediatricians, and psychiatrists will be presented by the University of Minnesota February 1 to 5, 1954. The course will consist principally of small-group discussions of common problems, led by recognized experts in the field. A minimum of didactic lecture material will be presented. The guest faculty will include Dr. Sherman Little, Director, Orthopsychiatric Department, Children's Hospital, Buffalo; Dr. Mabel Ross, Mental Health Consultant, U. S. Public Health Service, New York City; and Dr. Henry H. Work, assistant professor of pediatrics and psychiatry, University of Louisville, and medical professor of pediatrics and psychiatry, University of Louisville Medical School. The course will be presented under the direction of Dr. Reynolds A. Jensen, professor, departments of psychiatry and pediatrics, at the University of Minnesota Medical School. Lodging and meal accommodations are available at the Center for Continuation Study.

Announcements of Meetings

Local and national civic leaders concerned with community health, welfare, and recreation are cordially invited to attend a "coming of age" party on January 29, 1954, in St. Louis. The twenty-first birthday of the national Advisory Committee on Citizen Participation will be celebrated that evening in the Hotel Jefferson at the Biennial Convention Dinner of Community Chests and Councils of America. The committee is jointly sponsored by the C.C.C. and the National Social Welfare Assembly.

The event will pay tribute to the millions of "unpaid workers" who guide and promote, implement, and finance public and private agency programs all over the United States and Canada. It will include the conferring by the C.C.C. of its annual Red Feather Award for outstanding volunteer service, and a talk on "Citizen Responsibility—The Price of Freedom," by a distinguished speaker.

Born in 1933 as the "National Committee on Volunteers," the advisory committee's early years were devoted to encouraging greater

citizen participation in national and state conferences of social work, and wider use of volunteer helpers by recreation, health, and social-welfare agencies locally. It stimulated the establishment of many local volunteer bureaus during the thirties.

During World War II, the committee gave leadership and staff to the federal Civil Defense Volunteer Office program. In 1945 it was adopted by Community Chests and Councils of America and rechristened the Advisory Committee on Citizen Participation. The National Social Welfare Assembly joined C.C.C. in 1947 in sponsorship of the committee, the focus of which was broadened to include the community-service volunteer needs and programs of national agencies and citizen organizations.

High lights of the committee's operations since then have been the Vassar Symposium on Motivations of Volunteer Service, 1947; the 1948 Workshop of Citizen Groups (Washington, D. C.); and a series of volunteer workshops held across the country in connection with regional and state conferences. With the growth in the number of volunteer bureaus, 1950 saw the establishment of the Association of Volunteer Bureaus.

The development of citizen councils in neighborhoods of metropolitan areas brought about, in 1953, the formation of a National Committee on District Community Councils. Both the Association of Volunteer Bureaus and the National Committee on District Community Councils operate as regular subcommittees of the Advisory Committee on Citizen Participation.

Among the current committee's operations are the preparation of guides for board members, a special study of volunteers in education and recreation agencies, a fact-finding project on the rôle of civic organizations and citizen groups in health and welfare services, and a study of the question of citizens' advisory groups and boards in public departments.

Under the Advisory Committee on Citizen Participation, and financed by the C.C.C., year-round guidance and service to local communities are provided on methods of recruiting, training, referring, follow-up, and recognition of volunteers. A national newsletter, *Volunteer Viewpoint*, promotes the cause of volunteer service and serves as an exchange of volunteer news and citizen participation activities.

Approximately 40 national organizations interested in aspects of health and education are joining with the American College Health Association in sponsoring the Fourth National Conference on Health in Colleges, to be held May 5–8, 1954, at the Hotel Statler, New York, N. Y. Dr. J. L. Morrill, President of the University of Minnesota, is president of the conference. Previous conferences were held in 1931, 1936, and 1947.

The objectives of the conference will be to consider ways for protecting and improving the health of college students through comprehensive and integrated programs of health service and health education, and to formulate suggestions for relating college health programs to all other college functions. The theme will be: "Teamwork in Meeting the Health Needs of College Students."

Attendance of from four to five hundred college and university presidents, deans, physicians, nurses, psychologists, specialists in physical education, health educators, student counselors, and others who have a stake in the health of students, including students themselves, is expected, according to Dr. Dana L. Farnsworth, Medical Director of Massachusetts Institute of Technology, who is chairman of the conference executive committee.

Representatives of many of the sponsoring agencies met recently with the executive committee to help plan working seminars in which a cross-section of the interested disciplines will be able to pool their problems and experience. One basis for conference planning will be a questionnaire sent by Dr. Morrill to 200 college presidents throughout the United States.

The World Federation for Mental Health announces the Fifth International Congress on Mental Health, to be held in Toronto, August 14–21, 1954. The theme of the congress is: "Mental Health in Public Affairs." Internationally known leaders in the mental-health field will present papers of general interest at the plenary sessions. There will be technical sessions, each morning, consisting of scientific papers and round-table discussions, supplemented by smaller discussion groups.

For further information about the Congress write Miss Helen Speyer, International Service, The National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

The International Association for Child Psychiatry will hold an International Institute on Child Psychiatry on August 13 and 14, 1954, in conjunction with the Fifth International Congress on Mental Health. The theme of the institute is: "Emotional Problems of Children Under Six." Members of the institute will discuss prepared clinical case studies and research reports related to the treatment of young children. Papers will be submitted from the United States and other countries illustrating a variety of treatment methods and professional and cultural points of view. It is hoped that some broad principles of child psychiatry will emerge which will be useful to workers in this field.

Further information about the institute may be obtained from Miss Helen Speyer, Executive Officer, The International Association for Child Psychiatry, 1790 Broadway, New York 19, N. Y.

The International Committee on Group Psychotherapy is preparing a meeting on group psychotherapy in Toronto, Canada, in connection with the Fifth International Congress on Mental Health, August, 1954. The conference will promote the exchange of information and intensify personal contact between group therapists and group workers throughout the world.

An all-day series of meetings is planned for Thursday, August 12, 1954, in Toronto. The morning meeting will discuss the use of the group in mental health and in psychotherapy. Current practices in group psychotherapy with adults and with children and parents will be the topic for afternoon and evening meetings.

Representatives from 17 nations are sponsoring the meeting. They will present papers on various recent developments in the use of group psychotherapy (*e.g.*, with alcoholics, with delinquents, with the aged, and so on). The use of the group in education, in recreation, in industry, and in government will be discussed. In addition, plans are being made for a dinner meeting and a get-together of this international group.

For full details write to Dr. Wilfred C. Hulse, Chairman, International Committee on Group Psychotherapy (sponsored by the American Group Psychotherapy Association, Inc.), 110 West 96 Street, New York 25, N. Y.

Current Publications

The third report of the Expert Committee on Mental Health, of the World Health Organization, is devoted to the subject of the community mental hospital. In dealing with the essential mental-hospital accommodation, the report states that, while it is impossible to lay down hard-and-fast rules concerning the number of beds to be provided for patients who, by virtue of their behavior and their illness, must be segregated, a country, however underdeveloped, "which has less than one psychiatric bed per 10,000 of the population will be unable to provide even the crudest level of . . . 'emergency psychiatric in-patient care.'"

Much attention is paid in the report to the "atmosphere" in the community mental hospital as an important factor in the efficacy of treatment. "Too many psychiatric hospitals," it is noted, "give the impression of being an uneasy compromise between a general hospital and a prison." The rôle of the psychiatric hospital is quite different from that of either of these institutions: it should be a kind of "therapeutic community." Among the elements conducive to the creation of the needed atmosphere are the preservation of the patient's individuality, the assumption that patients are trustworthy and capable

of undertaking responsibility and displaying initiative, and the encouragement of good social behavior.

Architecturally, the mental hospital often shows the same influence of general hospital or prison. If it is to be a therapeutic community, it must be designed and planned as such. "If it is to support and recreate the sense of individuality in patients, it must not dwarf them by its size and by herding them together in thousands in giant monoblock buildings." Preferably, the hospital should be composed of groups of small buildings, spaced out in a natural area of woods, gardens, and farm lands.

Home care, institutions for aged patients, special hospitals, and psychiatric wards in general hospitals are considered to some extent in the report. Extramural activities and treatment are also discussed. Among the activities suggested in the report are the spreading of information to the public concerning the hospital itself and the nature of psychiatric illness, the development of mental-health education within the community, and the study both of the mental-health problems in the community and of the ways and habits of the community that are relevant to the solution of these problems. Such activities, plus close liaison between the psychiatric staff of the mental hospital and the other physicians in the community, should lead toward the setting-up of outpatient services, the development and rôle of which are described.

Copies of the report can be obtained, at a price of 25 cents each, from the Columbia University Press, International Documents Service, 2960 Broadway, New York 27, N. Y.

Pastoral Psychology, a monthly periodical devoted to the practical synthesis of the principles and techniques of clinical psychology, dynamic psychiatry, and psychiatric social work with spiritual and religious values, is publishing in January its first annual, devoted entirely to a listing of significant reference and resources materials for the minister, the clinical psychologist, the psychiatrist, and all other workers in the field of human behavior.

A large section of the annual will be devoted to a special listing and description of significant books published within recent years on psychology, psychiatry, and counseling, organized and graded by Professor Seward Hiltner and several members of the magazine's editorial advisory board, on the basis of the reading level and equipment of the individual reader. It will also contain a listing of mental-health films and plays, and an article on readings in psychoanalysis, with a listing of the outstanding books in the field, particularly emphasizing Sigmund Freud's work.

In addition, the annual will contain a listing of psychiatric services, such as resources for clinical training, resources for psychiatric treatment of children and adults, marriage-counseling services, a listing of private and public treatment resources for children with behavior disorders, private psychiatric hospitals, resources for the treatment of alcoholics, and so on. The annual will also contain a glossary of psychiatric technical words which appear frequently in the literature, as well as an index of materials that appeared in *Pastoral Psychology* during the past year.

Individual issues of the annual will be on sale at $1.00. Special quantity prices will be as follows: 1 to 4 copies—$1.00 per copy; 5 to 24 copies—$0.75 per copy; 25 to 99 copies—$0.60 per copy; 100 or over —$0.50 per copy. Orders should be sent to *Pastoral Psychology*, Great Neck, N. Y.

The National Association for Retarded Children has recently issued two publications of interest to parents of retarded children. The first is a pamphlet of 51 pages, entitled *The Three "R's" for the Retarded: A Program for the Training of the Retarded Child at Home*, by Naomi H. Chamberlain and Dorothy H. Moss. The pamphlet, as modestly described in its preface, is "a compilation of suggestions for help in training the mentally retarded child at home. All of the suggestions have been tried on various retarded children, and each suggestion is the direct outgrowth of questioning parents. They have asked so many times, 'But how do I teach my child? What should I do first?'

"There is nothing dramatically new or 100 per cent guaranteed in this pamphlet. Yet there has existed a great need for such guidance as it gives. Each suggestion included has been successfully tried with some child. It may help yours."

The twelve short chapters into which the pamphlet is divided deal with such subjects as "Your Child and His Toys," "Your Child and Discipline," "Helping Your Child Develop Through Play," "Helping Your Children Learn to Feed Himself," "Helping Your Child Learn to Dress Himself," "Helping Your Child Establish Good Toilet Habits," "Helping Your Child Develop Language and Speech."

The pamphlet can be ordered from the National Association for Retarded Children, P. O. Box 85, Wall Street Station, New York 5, N. Y. The price is 50 cents a copy; 30 cents a copy if ordered in quantities of 25 or more.

The second publication is a selected annotated list of publications on the subject of the retarded child, giving their prices and the names and addresses of the organizations that distribute them. This reading list also can be obtained from the National Association for Retarded Children, at the address given.